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Medicare Program; Hospice Wage Index for Fiscal Year 2009; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

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Medicare Program; Hospice Wage Index for Fiscal Year 2009

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule sets forth the hospice wage index for fiscal year 2009. In addition, this final rule finalizes the policy to phase out the Medicare hospice budget neutrality adjustment factor, and clarifies two wage index issues pertaining to the definition of rural and urban areas and multi-campus hospital facilities.

DATES: *Effective Dates:* These regulations are effective on October 1, 2008.

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SUPPLEMENTARY INFORMATION:

I. Background

A. General

1. Hospice Care

Hospice care is an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through use of a broad spectrum of professional and other caregivers, with the goal of making the individual as physically and emotionally comfortable as possible. Counseling services and inpatient respite services are available to the family of the hospice patient. Hospice programs consider both the patient and the family as a unit of care.

Section 1861(dd) of the Social Security Act (the Act) provides for coverage of hospice care for terminally ill Medicare beneficiaries who elect to receive care from a participating hospice. Section 1814(i) of the Act provides payment for Medicare participating hospices.

2. Medicare Payment for Hospice Care

Our regulations at 42 CFR part 418 establish eligibility requirements, payment standards and procedures, define covered services, and delineate the conditions a hospice must meet to be approved for participation in the Medicare program. Part 418 subpart G provides for payment in one of four prospectively-determined rate categories (routine home care, continuous home care, inpatient respite care, and general inpatient care) to hospices based on each day a qualified Medicare beneficiary is under a hospice election.

B. Hospice Wage Index

Our regulations at § 418.306(c) require each hospice's labor market to be established using the most current hospital wage data available, including any changes by the Office of Management and Budget (OMB) to the Metropolitan Statistical Areas (MSAs) definitions, which have been superseded by the Core Based Statistical Areas (CBSAs).

The hospice wage index is used to adjust payment rates for hospice agencies under the Medicare program to reflect local differences in area wage levels. The original hospice wage index was based on the 1981 Bureau of Labor Statistics hospital data and had not been updated since 1983. In 1994, because of disparity in wages from one geographical location to another, the Hospice Wage Index Negotiated Rulemaking Committee was formulated to negotiate a wage index methodology to be used for updating the hospice wage index. This Committee, functioning under a process established by the Negotiated Rulemaking Act of 1990, signed an agreement for the methodology to be used for updating the hospice wage index on April 13, 1995.

On August 8, 1997, we published in the **Federal Register** a final rule (62 FR 42860) implementing a new methodology for calculating the hospice wage index based on the recommendations of the negotiated rulemaking committee. The committee statement was included in the appendix of that final rule (62 FR 42883).

The hospice wage index is updated annually. Our most recent annual update final rule (72 FR 50214) published in the **Federal Register** on August 31, 2007, set forth updates to the hospice wage index for fiscal year (FY) 2008.

1. Raw Wage Index Values (Raw Pre-Floor, Pre-Reclassified Hospital Wage Index)

As described in the August 8, 1997 hospice wage index final rule (62 FR 42860), the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit. These raw wage index values are then subject to either a budget neutrality adjustment or application of the hospice floor to compute the hospice wage index used to determine payments to hospices.

Raw pre-floor, pre-reclassified hospital wage index values of 0.8 or greater are adjusted by the Budget Neutrality Adjustment Factor (BNAF). Raw pre-floor, pre-reclassified hospital wage index values below 0.8 are adjusted by the greater of: (1) The hospice BNAF; or (2) the hospice floor (which is a 15 percent increase) subject to a maximum wage index value of 0.8.

The BNAF has been computed and applied annually to the labor portion of the hospice payment. Currently, the labor portion of the payment rates is as follows: for routine home care, 68.71 percent; for continuous home care, 68.71 percent; for general inpatient care, 64.01 percent; and for respite care, 54.13 percent. The non-labor portion is equal to 100 percent minus the labor portion for each level of care.

2. Changes to Core-Based Statistical Area (CBSA) Designations

The annual update to the hospice wage index is published in the **Federal Register** and is based on the most current available hospital wage data, as well as any changes by the OMB to the definitions of MSAs, which now include CBSA designations.

3. Definition of Rural and Urban Areas

Each hospice's labor market is determined based on definitions of MSAs issued by OMB. In general, an urban area is defined as an MSA or New England County Metropolitan Area (NECMA) as defined by OMB. Under 42 CFR 412.64(b)(1)(ii)(C), a rural area is defined as any area outside of the urban area. The urban and rural area geographic classifications are defined in § 412.64(b)(1)(ii)(A) through (C), and have been used for the Medicare hospice benefit since implementation.

4. Areas Without Hospital Wage Data

When adopting OMB's new labor market designations in FY 2006, we identified some geographic areas where there were no hospitals, and no hospital wage index data on which to base the calculation of the hospice wage index. Beginning in FY 2006, we adopted a

policy to use the FY 2005 raw pre-floor, pre-reclassified hospital wage index value for rural areas when no hospital wage data were available. Under the CBSA labor market areas, there are no hospitals in rural locations in Massachusetts and Puerto Rico. We also adopted the policy that for urban labor markets without a hospital from which hospital wage index data could be derived, all of the CBSAs within the State would be used to calculate a statewide urban average raw pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. The only affected CBSA is 25980, Hinesville-Fort Stewart, Georgia.

In the FY 2008 final rule (72 FR 50214, 50217), in cases where there was a rural area without rural hospital wage data, we used the average raw pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs to represent a reasonable proxy for the rural area. This approach does not use rural data; however, the approach uses raw pre-floor, pre-reclassified hospital wage data, and is easy to evaluate, easy to update from year-to-year, and uses the most local data available. In the FY 2008 rule (72 FR at 50217), we noted that in determining an imputed rural raw pre-floor, pre-reclassified hospital wage index, we interpret the term ''contiguous'' to mean sharing a border. For example, in the case of Massachusetts, the entire rural area consists of Dukes and Nantucket counties. We determined that the borders of Dukes and Nantucket counties are contiguous with Barnstable and Bristol counties. Under the adopted methodology, the raw pre-floor, pre-reclassified hospital wage index values for the counties of Barnstable (CBSA 12700, Barnstable Town, MA) and Bristol (CBSA 39300, Providence-New Bedford-Fall River, RI-MA) were averaged, resulting in an imputed raw pre-floor, pre-reclassified rural hospital wage index for FY 2008.

We also noted that we do not believe that this policy would be appropriate for Puerto Rico, as there are sufficient economic differences between hospitals in the United States and those in Puerto Rico, including the payment of hospitals in Puerto Rico using blended Federal/Commonwealth-specific rates. Therefore, we believe that a separate and distinct policy for Puerto Rico is necessary. Any alternative methodology for imputing a raw pre-floor, pre-reclassified hospital wage index for rural Puerto Rico would need to take into account the economic differences between hospitals in the United States and those in Puerto Rico. While we have not yet identified an alternative methodology for imputing a raw pre-floor, pre-reclassified hospital wage index for rural Puerto Rico, we will continue to evaluate the feasibility of using existing hospital wage data and, possibly, wage data from other sources. For FY 2008, we used the most recent raw pre-floor, pre-reclassified hospital wage index available for Puerto Rico, which is 0.4047.

5. CBSA Nomenclature Changes

The OMB regularly publishes a bulletin that updates the titles of certain CBSAs. In the FY 2008 final rule (72 FR 50218), we noted that the FY 2008 rule and all subsequent hospice wage index rules and notices would incorporate CBSA changes from the most recent OMB bulletins. The OMB bulletins may be accessed at *http://www.whitehouse.gov/omb/bulletins/index.html*.

6. Hospice Payment Rates

Payment rates have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for FYs since 2002 will be the market basket percentage for the fiscal year. According to section 1814(i)(1)(C) of the Act, hospices are to use the inpatient hospital market basket as a proxy for a hospice market basket.

Historically, the rate update has been published through a separate administrative instruction issued annually in the summer to provide adequate time to implement system change requirements. Providers determine their payments by applying the hospice wage index in this final rule to the labor portion of the published hospice rates.

Requirements for Issuance of Regulations

Section 902 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended section 1871(a) of the Act and requires the Secretary, in consultation with the Director of the OMB, to establish and publish timelines for the publication of Medicare final regulations based on the previous publication of a Medicare proposed or interim final regulation. Section 902 of the MMA also states that the timelines for these regulations may vary but shall not exceed 3 years after publication of the preceding proposed or interim final regulation except under exceptional circumstances.

This final rule finalizes provisions proposed in the May 1, 2008 proposed rule. In addition, this final rule has been published within the 3-year time limit imposed by section 902 of the MMA. Therefore, we believe that the final rule is in accordance with the Congress' intent to ensure timely publication of final regulations.

II. Provisions of the Proposed Rule and Analysis of and Responses to Public Comments

On May 1, 2008, we published a proposed rule in the **Federal Register** (73 FR 24000) that set forth the proposed hospice wage index for FY 2009. We received 540 timely items of correspondence. The following is a summary of each of the proposals followed by our responses to these public comments.

A. Clarification of New England Deemed Counties

In the May 1, 2008 proposed rule, we proposed to amend § 418.306(c) to cross-reference to the definitions of urban and rural in the Inpatient Prospective Payment System (IPPS) regulations in 42 CFR Part 412 subpart D. In that proposed rule, we addressed the IPPS change in the designation of ''New England deemed counties,'' which are listed in § 412.64(b)(1)(ii)(B). These counties were deemed to be part of urban areas under section 601(g) of the Social Security Amendments of 1983. However, under the OMB geographic definitions, these counties were considered rural. In the FY 2008 IPPS final rule, CMS adopted a change that resulted in these counties no longer being ''deemed'' urban. The counties include Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. Of these five ''New England deemed counties,'' three (York County, Sagadahoc County, and Newport County) are included in metropolitan statistical areas defined by OMB and are therefore urban under the current IPPS labor market area definitions in § 412.64(b)(1)(ii)(A). The remaining two counties, Litchfield County and Merrimack County, are geographically located in areas that are rural under the current IPPS labor market area definitions.

In the August 22, 2007 FY 2008 IPPS final rule with comment period (72 FR 47130), § 412.64(b)(1)(ii)(B) was revised such that the two ''New England deemed counties'' that are still considered rural under the OMB definitions (Litchfield County, CT and Merrimack County, NH) are no longer considered urban effective for discharges occurring on or after October 1, 2007. Therefore, these two counties are considered rural in accordance with § 412.64(b)(1)(ii)(C). However, for

purposes of payment under the IPPS, acute care hospitals located within those areas are treated as being reclassified to their deemed urban area effective for discharges occurring on or after October 1, 2007 (see 72 FR 47337 through 47338). We also noted that this policy change was limited to the ''New England deemed counties'' IPPS hospitals only, and that any change to non-IPPS provider wage indexes would be addressed in the respective payment system rules. The hospice program does not provide for such geographic reclassification as the IPPS does.

The recommendations to adjust payments to reflect local differences in wages are codified in § 418.306(c) of our regulations; however there is no explicit reference to § 412.64 in § 418.306(c). Although § 412.64 is not explicitly referred to, the hospice program has used the definition of urban in § 412.64(b)(1)(ii)(A) and (B), and the definition of rural as any area outside of an urban area in § 412.64(b)(1)(ii)(C). We proposed to explicitly refer to those provisions in § 412.64 to make it absolutely clear how we define urban and rural for purposes of the hospice wage index. We received no comments on this proposal and will implement it as proposed.

Litchfield county, CT and Merrimack county, NH are considered rural areas for hospital IPPS purposes in accordance with § 412.64. Effective October 1, 2008, Litchfield county, CT will no longer be considered part of urban CBSA 25540 (Hartford-West Hartford-East Hartford, CT), and Merrimack county, NH will no longer be considered part of urban CBSA 31700 (Manchester-Nashua, NH). Rather, these counties will be considered to be rural areas within their respective States under the hospice payment system. When the raw pre-floor, pre-reclassified hospital wage index was adopted for use in deriving the hospice wage, it was decided not to take into account IPPS geographic reclassifications. This proposed policy to follow OMB designations of rural or urban, rather than considering some counties to be ''deemed'' urban, is consistent with our policy of not taking into account IPPS geographic reclassifications in determining payments under the hospice wage index.

We received no comments on this proposal, and will implement it as proposed without change.

B. Wage Data for Multi-Campus Hospitals

Historically, under the Medicare hospice benefit, we have established hospice wage index values calculated from the raw pre-floor, pre-reclassified hospital wage data (also called the IPPS wage index) without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. The wage adjustment established under the Medicare hospice benefit is based on the location where services are furnished without any reclassification.

For FY 2009, the data collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2004 were used to compute the 2008 raw pre-floor, pre-reclassified hospital wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. This 2008 raw pre-floor, pre-reclassified hospital wage index was used to derive the applicable wage index values for the hospice wage index because these data (FY 2004) are the most recent complete data (for information on the data used to compute the FY 2008 IPPS wage index, refer to the FY 2008 IPPS final rule with comment period (72 FR 47308 through 47309, 47315)).

Beginning in FY 2008, the IPPS apportioned the wage data for multi-campus hospitals located in different labor market areas (CBSAs) to each CBSA where the campuses are located (see the FY 2008 IPPS final rule with comment period (72 FR 47317 through 47320)). We are continuing to use the raw pre-floor, pre-reclassified hospital wage data as a basis to determine the hospice wage index values for FY 2009 because hospitals and hospices both compete in the same labor markets, and therefore, experience similar wage-related costs. We note that the use of raw pre-floor, pre-reclassified hospital (IPPS) wage data, used to derive the FY 2009 hospice wage index values, reflects the application of our policy to use that data to establish the hospice wage index. The FY 2009 hospice wage index values presented in this final rule were computed consistent with our raw pre-floor, pre-reclassified hospital (IPPS) wage index policy (that is, our historical policy of not taking into account IPPS geographic reclassifications in determining payments for hospice). For the FY 2009 Medicare hospice benefit, the wage index was computed from IPPS wage data (submitted by hospitals for cost reporting periods beginning in FY 2004 (just like the FY 2008 IPPS wage index)), which allocated salaries and hours to the campuses of two multi-campus hospitals with campuses that are located in different labor areas, one in Massachusetts and another in Illinois. Thus, the FY 2009 hospice wage index values for the following CBSAs are affected by this policy: Boston-Quincy, MA (CBSA 14484), Providence-New Bedford-Falls River, RI-MA (CBSA 39300), Chicago-Naperville-Joliet, IL (CBSA 16974), and Lake County-Kenosha County, IL-WI (CBSA 29404).

We received no comments on this proposal, and will implement it as proposed without change.

C. FY 2009 Hospice Wage Index With Phase Out of the Budget Neutrality Adjustment Factor (BNAF)

1. Background

The hospice final rule published in the **Federal Register** on December 16, 1983 (48 FR 56008) provided for adjustment to hospice payment rates to reflect differences in area wage levels. We apply the appropriate hospice wage index value to the labor portion of the hospice payment rates based on the geographic area where hospice care was furnished. As noted earlier, each hospice's labor market area is based on definitions of Metropolitan Statistical Areas (MSAs) issued by the OMB. For FY 2009, we proposed to use a raw pre-floor, pre-reclassified hospital wage index based solely on the CBSA designations.

As noted above, our hospice payment rules utilize the wage adjustment factors used by the Secretary for purposes of section 1886(d)(3)(E) of the Act for hospital wage adjustments. Again, we proposed to use the raw pre-floor and pre-reclassified hospital wage index data to adjust the labor portion of the hospice payment rates based on the geographic area where the beneficiary receives hospice care. We believe the use of the raw pre-floor, pre-reclassified hospital wage index data results in the appropriate adjustment to the labor portion of the costs. For the FY 2009 update to hospice payment rates, we proposed using the most recent raw pre-floor, pre-reclassified hospital wage index available at the time of publication.

Comment: A few commenters were unhappy with CMS' use of the raw pre-floor, pre-reclassified hospital wage index as the input for the hospice wage index, and suggested it is flawed. Some commenters noted that the hospital-based wage index has undergone multiple changes over the past 10 years and that providers were not invited to provide comment for CMS to consider when formalizing these changes. One commenter added that the existence of exceptions to the hospital wage index system in the form of reclassifications demonstrates the unfairness and inadequacy of the hospital-based wage index system.

Several commenters mentioned that a 2007 MedPAC report on the hospital wage index suggested that CMS repeal the existing hospital wage index, and develop a new one. The commenter stated that MedPAC recommended that CMS evaluate the use of the revised wage index in other Medicare payment systems, which includes hospice. A commenter asked CMS to devise a hospice-specific reimbursement system, rather than using the hospital-based wage index. Several of these commenters offered to work with CMS in reforming the wage index, and recommended use of the collaborative negotiated rulemaking process. They suggested that CMS use the established wage index methodology, including the BNAF, until a viable alternative is found.

In addition, a commenter wrote that hospices compete in the same labor market as hospitals for staff but hospitals do not use the same wage index, and that the wage index does not reflect the reality of wages in a healthcare community.

Response: The raw pre-floor, pre-reclassified hospital wage index was adopted in 1998 as the wage index from which the hospice wage index is derived. The Negotiated Rulemaking Committee considered several wage index options: (1) Continuing with Bureau of Labor Statistics data; (2) using updated hospital wage data; (3) using hospice-specific data; and (4) using data from the physician payment system. The Committee determined that the raw pre-floor, pre-reclassified hospital wage index was the best option for hospice. The raw pre-floor, pre-reclassified hospital wage index is updated annually, and reflects the wages of highly skilled hospital workers.

We agree that the hospital-based wage index has undergone some changes in the past 10 years. Those changes were put forward through rulemaking, which provided the public an opportunity to provide comments. Therefore, we disagree that hospice providers have not had an opportunity to comment on hospital wage index changes.

The reclassification provision provided at section 1886(d)(10) of the Act is specific to hospitals. We believe the use of the most recent available raw pre-floor and pre-reclassified hospital wage index results in the most appropriate adjustment to the labor portion of hospice costs as required in 42 CFR 418.306(c). Additionally, use of the unadjusted hospital wage data avoids further reductions in certain rural statewide wage index values that result from reclassification. We also note that the wage index adjustment is based on the geographic area where the beneficiary is located, and not where the hospice is located.

We continue to believe that the unadjusted hospital wage index, which is updated yearly and is used by many other CMS payments systems including home health, appropriately accounts for geographic variances in labor costs for hospices. Home health agencies and hospices are Medicare's only home-based benefits, and home health agencies and hospices share labor pools. In the future, when looking into reforming the hospice payment system, we will consider wage index alternatives, to include those recommended by MedPAC.

We are implementing as final the proposal to continue to use the raw pre-floor, pre-reclassified hospital wage index.

2. Areas Without Hospital Wage Data

In adopting the CBSA designations, we identified some geographic areas where there are no hospitals, and thus no hospital wage data on which to base the calculation of the hospice wage index. These areas were described in section I.B.4 of the proposed rule (73 FR 24004). Beginning in FY 2006, we adopted a policy that, for urban labor markets without an urban hospital from which a raw pre-floor, pre-reclassified hospital wage index can be derived, all of the urban CBSA raw pre-floor, pre-reclassified hospital wage index values within the State would be used to calculate a statewide urban average raw pre-floor, pre-reclassified hospital wage index to use as a reasonable proxy for these areas. Currently, the only CBSA that would be affected by this policy is CBSA 25980, Hinesville-Fort Stewart, Georgia. We proposed to continue this policy for FY 2009.

Currently, the only rural areas where there are no hospitals from which to calculate a raw pre-floor, pre-reclassified hospital wage index are in Massachusetts and Puerto Rico. In August 2007 (72 FR 50217) we adopted the following methodology for imputing rural raw pre-floor, pre-reclassified hospital wage index values for areas where no hospital wage data are available as an acceptable proxy. We imputed an average raw pre-floor, pre-reclassified hospital wage index value by averaging the raw pre-floor, pre-reclassified hospital wage index values from contiguous CBSAs as a reasonable proxy for rural areas with no hospital wage data from which to calculate a raw pre-floor, pre-reclassified hospital wage index. In determining an imputed rural raw pre-floor, pre-reclassified hospital wage index, we define ''contiguous'' as sharing a border. In the proposed rule, we proposed to apply this methodology for imputing a rural raw pre-floor, pre-reclassified hospital wage index for those rural areas without rural hospital wage data in FY 2009. For Massachusetts, rural Massachusetts currently consists of Dukes and Nantucket Counties. We determined that the borders of Dukes and Nantucket counties are ''contiguous'' with Barnstable and Bristol counties. We did not receive any comments on this proposal, and are implementing it as proposed.

As we noted in our proposed rule, we do not believe that this methodology for imputing a rural raw pre-floor, pre-reclassified hospital wage index value is appropriate for Puerto Rico. We noted that there are sufficient economic differences between the hospitals in the United States and those in Puerto Rico, including the fact that hospitals in Puerto Rico are paid on blended Federal/Commonwealth-specific rates, to make a separate distinct policy for Puerto Rico necessary.

We did not receive any comments on this proposal, and are implementing it as proposed without change. Therefore, in this final rule, for FY 2009, we are continuing to use the most recent raw pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047. This raw pre-floor, pre-reclassified hospital wage index value is then adjusted upward by the hospice floor in the computing of the final FY 2009 hospice wage index.

3. Phase Out of the Budget Neutrality Adjustment Factor (BNAF)

As previously stated, the current hospice wage index methodology was developed through a negotiated rulemaking process and implemented in 1997. The rulemaking committee sought to address the inaccuracies in the original Bureau of Labor Statistics (BLS)-based hospice wage index, account better for disparities from one geographic location to another, and develop a wage index that would be as accurate, reliable and equitable as possible. The resulting hospice wage index reflects a special adjustment (a BNAF) to ensure payments in the aggregate are budget neutral to payments using the original 1983 hospice wage index. The adjustment, which is still in place today, results in providers currently receiving about 4 percent more in payments than they would have received if the adjustment factor were not applied. We believe the rationale for maintaining this adjustment is outdated, as explained in detail below, particularly given the

amount of time that has elapsed since it was first put into place and the continuing growth that is occurring in the hospice benefit. In the proposed rule, we proposed to phase out this adjustment over 3 years, reducing it by 25 percent in FY 2009, by an additional 50 percent for a total of 75 percent in FY 2010, and eliminating it completely in FY 2011. Additionally, from a parity perspective, because hospices and home health agencies have a similar labor mix, we believe that adjusting for geographic variances in both of these Medicare home-based benefits with the raw pre-floor and pre-reclassified hospital wage index is appropriate.

The original hospice wage index that was used when the benefit was first implemented was based on the 1981 BLS hospital data and had not been updated from 1983 until the current raw pre-floor and pre-reclassified hospital wage index was adopted. During earlier attempts to update the original hospice wage index, the hospice industry raised concerns over the adverse financial impact of a new wage index on individual hospices and a possible overall reduction in Medicare payments. Thus, the result was that in the absence of agreement on a new wage index, we continued to use the original wage index that was clearly obsolete for geographically adjusting Medicare hospice payments (see ''Medicare Program; Notice Containing the Statement Drafted by the Committee Established to Negotiate the Wage Index to Be Used to Adjust Hospice Payment Rates Under Medicare'', November 29, 1995, 60 FR 61264).

Changing to a new, more accurate wage index would result in some areas gaining as their wage index value would increase, but other areas would see declines in payments as their wage index value dropped. In 1994, we noted that a majority of hospices would have their wage index reduced with the new wage index that is based on using the raw pre-floor, pre-reclassified hospital wage index. These reductions would have occurred for two key reasons: (1) Hospices were located in areas where the original hospice wage index was artificially high due to flaws in the 1981 BLS data; and (2) hospices were located in areas where wages had gone down relative to other geographic areas (see ''Hospice Services Under Medicare Program: Intent to Form Negotiated Rulemaking Committee'', October 14, 1994, 59 FR 52130).

Because of the negative impact to certain areas that was expected with the change to a new wage index, a committee (the Committee) was formulated in 1994, under the process established by the Negotiated Rulemaking Act of 1990 (Pub. L. 101–648). The Committee was established to negotiate the hospice wage index methodology rather than to go through the usual rulemaking process. On September 4, 1996, we published a proposed rule (61 FR 46579) in which we proposed a methodology to update the hospice wage index used to adjust Medicare hospice payment rates. This proposed methodology contained the negotiated rule making committee's recommendations.

In formulating the provisions of that proposed rule, the Committee considered criteria in evaluating the available data sources. These criteria included the need for fundamental equity of the wage index, data that reflected actual work performed by hospice personnel, compatibility with wage indexes used by CMS for other Medicare providers, and availability of the data for timely implementation.

The Committee agreed that the hospice wage index be derived from the 1993 hospital cost report data and that these data, prior to reclassification, would form the basis for the FY 1998 hospice wage index. That is the raw pre-floor, pre-reclassified hospital wage index would not be adjusted to take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act. The methodology is codified in § 418.306(c). The hospice wage index for subsequent years would be based on raw pre-floor, pre-reclassified hospital wage index data.

The Committee was also concerned that while some hospices would see increases in their payments, use of the raw pre-floor, pre-reclassified hospital wage index as the wage index for hospices would result in a net reduction in aggregate Medicare payments for hospices. As noted above, a majority of hospices would have had their wage index lowered by using the new wage index because the prior hospice wage indices were based on outdated data which were artificially high due to flaws in the 1981 BLS data, and because some hospices were located in areas where wages had gone down relative to other geographic areas. The reduction in overall Medicare payments if a new wage index were adopted was noted in the November 29, 1995 final rule (60 FR 61264). Therefore, the Committee also decided that for each year in updating the hospice wage index, aggregate Medicare payments to hospices would remain budget neutral to payments as if the 1983 wage index had been used.

As decided upon by the Committee, budget neutrality means that, in a given year, estimated aggregate payments for Medicare hospice services using the updated hospice values will equal estimated payments that would have been made for these services if the 1983 hospice wage index values had remained in effect, after adjusting the payment rates for inflation. Therefore, although payments to individual hospice programs may change each year, the total payments each year to hospices would not be affected by using the updated hospice wage index because total payments would be budget neutral as if the 1983 wage index had been used. To implement this policy, a BNAF would be computed and applied annually.

The BNAF is calculated by computing estimated payments using the most recent completed year of hospice claims data. The units (days or hours) from those claims are multiplied by the updated hospice payment rates to calculate estimated payments. The updated hospice wage index values are then applied to the labor portion of the payments. For this final rule, that means estimating payments for FY 2009 using FY 2007 hospice claims data as of March 2008, and applying the estimated updated FY 2009 hospice payment rates (updating the FY 2008 rates by the FY 2009 market basket update). The final FY 2009 hospice wage index values are then applied to the labor portion only. The procedure is repeated using the same claims data and payment rates, but using the 1983 BLS-based wage index instead of the updated raw pre-floor, pre-reclassified hospital wage index. The total payments are then compared, and the adjustment required to make total payments equal is computed; that adjustment factor is the BNAF.

All raw pre-floor, pre-reclassified hospital wage index values of 0.8 or greater would be adjusted by the BNAF, which would be calculated and applied annually. Also, all raw pre-floor, pre-reclassified hospital wage index values below 0.8 would receive the greater of the following: (1) A 15-percent increase subject to a maximum hospice wage index value of 0.8; or (2) an adjustment by the BNAF.

While the Committee sought to adopt a wage index methodology that would be as accurate, reliable, and equitable as possible, the Committee also decided to incorporate a BNAF into the calculation of the hospice wage index that would otherwise apply in order to mitigate adverse financial impacts some hospices would experience through a decrease in their wage index value by transitioning to a raw pre-floor, pre-reclassified hospital wage index.

In the August 8, 1997, final rule (62 FR 42860), we indicated that the annual updates of the hospice wage index values would be made in accordance with the methodology agreed to by the Committee. We also noted that in the event that we decide to change this methodology by which the hospice wage index is computed, we would propose to do so in the **Federal Register**. In the May 2008 proposed rule, we proposed to change this methodology.

In FY 1998, the BNAF was 1.020768 and in FY 2008, the BNAF was 1.066671. Any raw pre-floor, pre-reclassified hospital wage index value greater than 0.8 was increased by over 2 percent in FY 1998 and increased by almost 7 percent in FY 2008. In FY 2008, this adjustment resulted in hospice providers receiving about 4 percent more in payments than they would have received if the BNAF had not been applied.

The Committee also recommended that the transition to the new hospice wage index occur over 3-years, from FY 1998 to FY 2001. The intent of both the 3-year transition and the budget neutrality adjustment was to mitigate the negative financial impact to many hospices resulting from the wage index change. Additionally, the committee sought to ensure that access to hospice care was not jeopardized as a result of the wage index change.

We believe that the rationale for maintaining the BNAF is outdated for several reasons.

First, the original purpose of the BNAF was to prevent reductions in payments to the majority of hospices whose wage index was based on the original hospice wage index which was artificially high due to flaws in the 1981 BLS data. Additionally, the BNAF was adopted to ensure that aggregate payments made to the hospice industry would not be decreased or increased as a result of the wage index change. While incorporating a BNAF into hospice wage indices could be rationalized in 1997 as a way to smooth the transition from an old wage index to a new one, since hospices have had plenty of time to adjust to the then new wage index, it is difficult to justify maintaining in perpetuity a BNAF which was in part compensating for artificially high data to begin with.

Second, the new wage index adopted in 1997 resulted in increases in wage index values for hospices in certain areas. The BNAF applies to hospices in all areas. Thus, hospices in areas that would have had increases without the BNAF received an artificial boost in the wage index for the past 11 years. We believe that continuation of this excess payment can no longer be justified.

Third, an adjustment factor that is based on 24-year-old wage index values is not in keeping with our goal of using a hospice wage index that is as accurate, reliable, and equitable as possible in accounting for geographic variation in wages. We believe that those goals can be better achieved by using the raw pre-floor, pre-reclassified hospital wage index, without the outdated BNAF, consistent with other providers. For instance, Medicare payments to home health agencies, that utilize a similar labor mix, are adjusted by the raw pre-floor, pre-reclassified hospital wage index without any budget neutrality adjustment. We believe that using the raw pre-floor, pre-reclassified hospital wage index provides a good measure of area wage differences for both these home-based reimbursement systems.

Fourth, in the 13 years since concerns about the impact of switching from an old to a new wage index were voiced, the hospice industry and hospice payments have grown substantially. Hospice expenditures in 2006 were $9.2 billion, compared to about $2.2 billion in 1998. Aggregate hospice expenditures are increasing at a rate of about $1 billion per year. MedPAC reports that expenditures are expected to grow at a rate of 9 percent per year through 2015, outpacing the growth rate of projected expenditures for hospitals, skilled nursing facilities, and physician and home health services. We believe that this growth in Medicare spending for hospice indicates that the original rationale of the BNAF, to cushion the impact of using the new wage index, is no longer justified. These spending growth figures also indicate that any negative financial impact to the hospice industry as a result of eliminating the BNAF is no longer present, and thus the need for a transitional adjustment has passed.

Fifth, 13 years ago the industry also voiced concerns about the negative financial impact on individual hospices that could occur by adopting a new wage index. In August 1994 there were 1,602 hospices; currently there are 3,111 hospices. Clearly any negative financial impact from adopting a new wage index in 1997 is no longer present, or we would not have seen this growth in the industry. The number of Medicare-certified hospices has continued to increase, with a 26 percent increase in the number of hospice providers from 2001 to 2005. This ongoing growth in the industry also suggests that phasing out the BNAF would not have a negative impact on access to care. Therefore, for these reasons, we believe that continuing to apply a BNAF for the purpose of mitigating any adverse financial impact on hospices or negative impact on access to care is no longer necessary.

Finally, we proposed to phase out the BNAF over a 3-year period, reducing the BNAF by 25 percent in FY 2009, by 75 percent in FY 2010, and eliminating it in FY 2011. We believe that the proposed 3-year phase-out period will reduce any adverse financial impact that the industry might experience if we eliminated the BNAF in a single year. We also proposed to maintain the hospice floor, which offers protection to hospices with raw pre-floor, pre-reclassified hospital wage index values less than 0.8, noting that the steps in the calculation which involve the BNAF will become unnecessary. We are implementing the BNAF phase-out as proposed, and maintaining the hospice floor as proposed.

We received several comments on the phase-out of the BNAF. Specific comments and our responses to these comments are as follows:

Comment: Several commenters disputed CMS' description of the purpose of the BNAF in the proposed rule. The commenters stated CMS asserted that the purpose was to smooth the transition from an outdated BLS-based wage index to the hospital-based wage index in 1998, the language in several payment rules suggested that the BNAF was not a time-limited adjustment and was to be applied annually, during and after the transition to the hospital-based wage index. One comment supported keeping the BNAF, stating that a payment reduction for FY 2009 to FY 2011 is no less disruptive than any payment reduction which occurred through the wage index transition in 1997. Another commenter stated that the hospice negotiated wage index rule that was finalized by CMS in 1997 recognized the need to include a budget neutrality adjustment to offset the flaws in the hospital wage index, and therefore protect the viability of hospices. The commenter also stated that reason remains as valid today as eleven years ago. Another commenter said CMS' rationale for phasing out the BNAF suggested that eliminating the BNAF would restore fairness to the hospice wage index, when in reality no wage index methodology is perfect. Other commenters stated that CMS has previously recognized that BNAF protects hospices from inadequacies in the hospital wage index, and inadequacies in the hospice payment rates. Another commenter stated that the BNAF was put into place because of the dramatic changes triggered by

implementation of the new wage index, so that access to care was protected.

In addition, a commenter asserted that the fundamental reason for the BNAF was that no component of the current reimbursement system accurately replicates hospice costs. A commenter also indicated that CMS stated that hospice payments and providers had increased over the past 10 years, and that the hospice wage index methodology is dated. The commenter further stated that by those standards, the wage index model used by every Medicare provider type would need revision. Furthermore, a commenter asked why, other than time passing, is the BNAF outdated. Commenters indicated that the rationale for applying the BNAF originally is still valid.

Response: We continue to believe that the hospice wage index negotiating committee intended the BNAF to mitigate the negative financial impact of the 1998 hospice wage index change. We continue to believe that because of the growth in the industry and the amount of time that has passed since the transition, the rationale for maintaining the BNAF is no longer justified. In addition, from a parity perspective, we believe that an raw pre-floor, pre-reclassified hospital wage index is appropriate for use in adjusting rates for geographic variances in both of our home-based benefits, hospice and home health. Nothing in our data analysis has shown us that hospice labor costs differ substantially from home health labor costs. Therefore, we believe we can no longer justify the 6 percent increase in the hospice wage index, which results from the BNAF. We agree with the commenter that BNAF was put into place so that beneficiary access to hospice care would be protected. We believe the Committee was primarily concerned about those areas of the country that would see their payments reduced as a result of the wage index change. The Committee was concerned that the payment reductions might affect the viability of hospices in these areas, thus ultimately risking access to care. The Committee intended that aggregate payments to hospices not be reduced as a result of the wage index change. We do not believe that the Committee foresaw the amount of growth in the number of new hospices that would occur over the following decade. While we agree with the commenter that our regulations describe that the BNAF be applied during and after the transition to the new wage index, we continue to believe that those decisions were made as part of the negotiations to address transitional issues, and do not negate our ability to make future policy changes. We believe that our regulations, the negotiating committee statement, and the negotiating committee workgroup notes support these beliefs. We also believe that given the current industry climate, it is appropriate that a policy change now occur.

The decision to transition from the BLS-based wage index to the hospital-based wage index was a long process. In the October 14, 1994, proposed rule (59 FR 52130), we noted that both CMS (formally HCFA) and industry projections indicated that most hospices would have their wage indices lowered if a new wage index were based on unadjusted hospital data. The preamble of the final rule stated that, ''During the discussions preliminary to developing a new wage index, the industry voiced concerns over the adverse financial impact of a new wage index on individual hospices and a possible reduction in overall Medicare hospice care payments'' (59 FR 52130). There were also concerns that access to hospice care could be affected. We noted that as a result of the impact of the lower payments to hospices in the aggregate, the new wage index would have to be at least budget neutral (59 FR 52131). The Committee Statement of April 13, 1995, which was published in a notice on November 29, 1995 (60 FR 61265), said that we would apply a factor to achieve budget neutrality, and noted that budget neutrality meant that aggregate Medicare hospice payments using the new hospital-based wage index would have to equal estimated payments that would have been made under the original hospice wage index.

We do not believe that the Committee foresaw the tremendous growth in the industry. As a result of this growth, the surge of new entrants into the industry over the past 10 years has benefited from this adjustment. We continue to believe that the committee adopted the BNAF to help existing hospices transition to the 1998 wage index change, and did not expect that the BNAF would result in these payment increases to new providers in perpetuity. Impact analysis performed by participants in the negotiating process showed pockets of the country where the migration to the new hospital wage index would result in wage index values decreasing nearly 30 percent. The committee was clearly concerned about hospice viability in those areas of the country, with a corresponding concern about access to care. We continue to believe that the unique BNAF methodology, coupled with the 3-year transition period, served to address those transitional concerns. It also continues to be our belief that because of the growth in the number of hospices, and the growth in the beneficiaries served that has occurred during the last decade, the committee's goal to ensure that access to hospice care not be reduced as a result of the wage index change has been achieved. Therefore, we believe that this unique methodology for achieving budget neutrality has served its purpose and is no longer necessary to be continued.

We disagree with the commenters who wrote that the BNAF was intended to offset flaws in the hospital wage index or address inadequacy of the hospice payment rates. None of our hospice regulations or notices from 1994 to 1998 which deal with the transition to a new wage index indicated that the BNAF was put into place because of flaws in the hospital-based wage index, rate inadequacies, or because of any inaccurate replication of hospice costs under the current reimbursement system. We continue to believe, as the Committee did, that the raw pre-floor, pre-reclassified hospital wage index is currently the best choice for use in deriving the hospice wage index.

We agree with the commenter that the language in the August 8, 1997 final rule indicated that the BNAF would be applied during and after the transition period (62 FR 42862), however this language did not imply that the BNAF could not be changed or eliminated. That same final rule also included a provision for us to change the wage index methodology, through notice and comment rulemaking (62 FR 42863).

In our rationale for the BNAF phase-out, we noted the increase in payments and in the number of providers to show that the hospice industry was growing. Growth such as this, rather than industry contraction, typically occurs in a favorable business climate. The presence of a favorable business climate suggests that concerns about the financial impact of changing to a new wage index had passed. Finally, we did not state that all hospice wage index methodology was outdated, but only that the BNAF was outdated, and we continue to believe that is the case.

Given that the impact of the BNAF phase-out is relatively small (1.1 percent payment reduction for FY 2009), and is being offset by a 3.6 percent market basket update, we do not feel that the phase-out will be disruptive to the hospice industry. However, we will monitor the impact as the phase-out occurs.

Comment: A commenter wrote that CMS justified phasing out the BNAF in part because the combination of increases in the wage index in certain

areas with the BNAF led to an artificial boost in the wage index for the past 11 years, which CMS concluded was an excess payment. The commenter also stated that CMS said that if there had been no wage index change in 1997, the total payments to hospices would be greater than the payments that will be made if the proposal is implemented. The commenter concludes that there is no excess spending triggered by the BNAF, but instead there is an unauthorized reduction under the CMS proposal.

Another commenter felt that CMS is singling out the BNAF because some hospices benefited more from it than others. The commenter also suggested that CMS change the methodology for the limited number of hospices that benefited unduly from the ''artificial boost'' given by the BNAF.

In addition, a commenter stated that CMS had indicated one reason for the BNAF phase-out was because the growth in hospice expenditures indicates that any negative financial impact from the transition to the hospital-based wage index in 1998 was no longer present. The commenter indicated that CMS assumed this growth in spending was excess spending, and that CMS had put forward no evidence that there was excess spending in hospice versus appropriate increases in spending.

Response: We continue to believe that applying the BNAF to the raw hospital-based wage index does not, as accurately as possible, account for geographic variances in hospice labor costs. When the hospice industry changed from the BLS-based wage index to the raw pre-floor, pre-reclassified hospital wage index, it began using more accurate, more current data which are updated annually. When that transition occurred, there were hospices whose wage index value increased, but many hospices saw their wage index value decrease. This is because the BLS-based wage index values, which were applied to hospice payments, were artificially high in some areas of the country. The Committee itself acknowledged that the BLS data were ''inaccurate and outdated'' in its Committee Statement (62 FR 42883). The hospital-based wage index was considered more accurate, even though its wage index values were lower for many hospices. Therefore before the transition to the hospital-based wage index, many hospices were receiving payments that were inflated due to the artificially high BLS-based wage index.

In addition, the BNAF was put into place to mitigate the adverse financial impact to hospice providers of changing wage indices, since the change would lead to a reduction in payments, which could threaten access to care. However, as we previously described in the comment above, the BNAF has been applied not only to those hospices that were in existence at the time of the wage index change, but also to those new hospices that were established after 1998. We continue to believe that these new entrants have received an artificial boost to their payments as a result of the BNAF, which was not the intent of the negotiating committee.

The commenter is correct that if the hospice industry had not adopted the hospital-based wage index, but had remained with the BLS-based data, each year's total Medicare hospice payments would be higher than they will be when the BNAF is phased out. However, as noted above, because of the inaccuracy and outdatedness of the BLS-based wage data, those payments would also be inaccurate, and CMS must do its best to ensure the accuracy of Medicare payments.

The commenter correctly noted that we feel that the growth in hospice expenditures indicates that the need to mitigate any adverse financial impact from the change to a hospital-based wage index has passed. However we did not assume that this growth was due to excess spending associated with the BNAF. We recognize that many factors contribute to expected and appropriate growth in spending, including increased numbers of Medicare beneficiaries eligible for hospice care; increased awareness of the benefit by beneficiaries, their families, and physicians; some longer lengths of stay; etc.

We believe that the growth in Medicare hospice expenditures indicates the overall good financial health of the hospice industry and that this further demonstrates that the BNAF has outlived its usefulness and is no longer appropriate. As stated previously, we believe that given the current industry climate, it is appropriate that a policy change to phase out the BNAF be implemented.

Comment: A commenter wrote that CMS had justified the BNAF phase-out by noting that there had been an 86 percent increase in growth in the number of hospices. The commenter maintained that growth in the number of hospice providers does not demonstrate that hospices can absorb the payment reduction triggered by the BNAF phase-out. The commenter also stated that CMS does not know the financial status of those hospices or the level of demand for their services.

Several commenters stated that CMS has concluded that the growth in the hospice benefit was due to the BNAF, thereby justifying its elimination. The commenters noted a number of factors that have contributed to the hospice industry's growth, including an increased number of beneficiaries using the benefit, longer lengths of stay, increased acceptance of hospices for end-of-life care by the physician and patient/family communities, changes in the mix of patients using hospice, and educational efforts by providers and by CMS to beneficiaries and health care providers.

Several commenters felt that the proposed BNAF reduction is a reaction to increasing hospice reimbursements overall. Another commenter stated that hospice is a small portion of all Medicare spending.

Response: We appreciate these comments. As we indicated in our responses, the FY 2009 financial impact of the BNAF phase-out is no more than a 1.1 percent reduction in payments. Therefore, with a 3.6 percent market basket update factor for FY 2009, we do not believe that there will be a significant adverse effect on the new providers, or on long-standing providers. We agree that demand for hospice services is growing as the U.S. population ages, and as the baby boomer generation begins to be eligible for Medicare.

We disagree with the commenter's suggestion that CMS does not know the financial status of hospices. In fact, the Medicare Payment Advisory Commission (MedPAC) has performed extensive analysis on various aspects of hospice financial performance and utilization trends over the last few years, including an assessment of growth trends in the hospice industry. We believe that both the growth in hospice expenditures and the growth in the number of hospices are indicators of financial stability in the industry, especially given the growth surge in the number of for-profit providers. MedPAC noted that hospice care has changed considerably since the benefit's implementation. In 1983 most providers were nonprofits affiliated with religious or community organizations, but now for-profit hospices constitute the majority of providers and the vast majority of new entrants into the program since 2000 (MedPAC, p. 206). In 1998, for-profit providers comprised 26.9 percent of the industry (63 FR 53456), while in 2007, for-profits comprised 51 percent (MedPAC, p. 216). The growth in not-for-profit hospices since 1998 has remained relatively flat.

MedPAC has also provided some information about the financial health of hospices, particular those who are new entrants into the market. MedPAC noted that hospices that began participating in the market in 2000 or after had consistently and substantially higher margins than those participating in Medicare before 2000. In addition, these higher margins are consistent with the growth in the number of for-profit providers (MedPAC, p. 223–224). Therefore, we do not believe that the newer entrants will be more affected by the BNAF reduction than older hospices.

We disagree with the comment that we asserted that the growth in the hospice industry was due to the BNAF or that the BNAF reduction is a reaction to the growth in hospice reimbursements. However, the commenters correctly noted several factors that have contributed to industry growth. We indicated that the BNAF phase-out was not a reaction to that growth—in the proposed rule, rather we stated that the BNAF was put in place to mitigate any adverse financial impact that individual hospices might experience as a result of transitioning to the new hospital-based wage index in 1998. We note that industries do not typically expand and grow during times of financial adversity; often there is industry contraction instead. We stated that the growth in the industry is an indication that any adverse financial effects of transitioning to a new wage index had ended.

We agree that relative to all Medicare spending, hospice spending is a small portion accounting for an expected 2.3 percent of spending overall in FY 2009. However, we estimate that hospice spending will more than double in the next 10 years. The growth in hospice spending has outpaced the rate of growth for other Medicare provider types. Furthermore, CMS has a responsibility to safeguard trust fund dollars by paying accurately and appropriately for all Medicare services. Finally, we disagree with the commenter that the proposed reduction in the BNAF is simply a reaction to increasing hospice reimbursements. Rather, as we have stated in the previous responses, we believe that the purpose of the BNAF was to mitigate the negative financial impact of a 1998 wage index change. We believe this mitigation for the transition to a ''new'' wage index is no longer necessary. We also believe that phasing out the BNAF places both Medicare home-based benefits on a more equal footing in terms of recruiting staff.

Comment: A commenter stated that cutting hospice payments disregards the significant, collaborative progress made in the Medicare hospice program over the last decade. A few commenters stated that CMS circumvented Congress by going through rulemaking to propose and possibly finalize a BNAF phase-out. Several commenters suggested CMS should use negotiated rulemaking to refine payment policy such as the BNAF. Another commenter stated that the wage index calculation is not and never has been intended to be used as a method to form payment policy. This commenter stated that role historically has been reserved for Congress. Another commenter stated that the BNAF phase-out was an administrative proposal put forward in the President's budget, and therefore should be enacted by Congress rather than effectuated through CMS rulemaking. Another commenter stated that the Secretary of the Department of Health and Human Services is required to propose reforms to the wage index calculations. One commenter stated that the proposed rulemaking process administratively circumvented the legislative intent to maintain and ensure adequate hospice funding levels.

Response: We appreciate these comments, but respectfully disagree with the commenters. The BNAF was put into place through use of a Negotiated Rulemaking Committee. We recognized that the wage index methodology, including the BNAF, could be changed when we included the following statement in Section IV (B) of the August 8, 1997 Final Rule entitled ''Medicare Program; Hospice Wage Index'' (62 FR 42863):

> The annual updates will update the hospice wage index values according to the methodology agreed to by the rulemaking committee and implemented by this final rule. In the event that we decide to change the methodology by which the wage index is computed, this will be reflected in a proposed rule published in the **Federal Register**.

The ''we'' in this paragraph refers to CMS (formally HCFA), which published the final rule in 1997. It is clear from this statement that the wage index methodology, including the BNAF, is subject to changes by CMS, and that any such changes do not have to go through negotiated rulemaking, but rather through our rulemaking process of publishing proposed and final rules in the **Federal Register**. There is no statutory requirement that requires wage adjustment methodology changes to go through Congress. While legislative proposals in the President's Budget require Congressional action, administrative proposals in the budget simply indicate intended administrative action, and do not require any Congressional action.

We believe that the intent of the BNAF was to protect hospice payments during the transition to the hospital-based wage index. The growth in the industry and in payments suggests that the industry has adequate funding levels, and is one reason for our proposal to phase out the adjustment.

We value the collaborative process, but do not feel that it is limited to Negotiated Rulemaking. The notice and comment rulemaking process, which we are following, allows for industry input and comment and is the general process by which changes to Medicare payment policy most often occur. We look forward to continuing to work with the industry in the future.

Comment: Many commenters stated that achieving budget neutrality was always a goal of the negotiated rulemaking process. A commenter disputed CMS' assertion that the BNAF was intended to prevent reductions in payments to the majority of hospices whose wage index was based on the original hospice wage index, which was artificially high due to flaws in the BLS data, and stated that the BNAF was never a point of contention during the Negotiated Rulemaking Process. The commenter stated that before the Negotiated Rulemaking Committee began its negotiations, CMS (formally HCFA) indicated that the wage index could not be used as a tool to increase payments to hospices, nor would it be used as a tool to lower aggregate payments to hospices. The commenter quoted our regulation (59 FR 52131), which stated that ''We [HCFA] consider it a given of negotiation that any revised wage index would have to be at least budget neutral; that is, total aggregate payments for the same services could not be more using the revised wage index than if such payments were made using the current index.''

Response: We stand by our assertion that the BNAF was intended to prevent reductions in payment, and point to the quote from the 1994 proposed rule (59 FR 52131), which the commenter included that the BNAF was designed to protect aggregate payments. We did not state or imply that the adoption of the BNAF was a point of contention during Negotiated Rulemaking. Rather, we said that the BNAF was now outdated, and is no longer needed for the reasons given in the proposed rule (73 FR 24006).

It is clear that we have the authority to make changes to the hospice wage index methodology, as noted in the August 8, 1997 final rule (62 FR 42862):

''In the event we decide to change the methodology by which the wage index is computed, this will be reflected in a proposed rule published in the **Federal Register**.

a. Effects of Phasing Out the BNAF Using the Published FY 2008 Hospice Wage Index

In the proposed rule, we used the August 31, 2007 FY 2008 hospice wage index (72 FR 50214) to illustrate the effects of phasing out the BNAF over 3 years. This analysis and discussion is for illustrative purposes only and does not affect any of the hospice wage index values for FY 2008.

The BNAF that was calculated and applied to the 2007 raw pre-floor, pre-reclassified hospital wage index values was 6.6671 percent. We will reduce the BNAF by 25 percent for FY 2009, by 75 percent for FY 2010, and eliminate it altogether for FY 2011 and beyond. A 25 percent reduction in the BNAF can be accomplished by blending 75 percent of the FY 2008 hospice wage index that applied the full 6.6671 percent BNAF with 25 percent of the FY 2008 hospice wage index that used no BNAF. This is mathematically equivalent to taking 75 percent of the full BNAF value, or multiplying 0.066671 by 0.75, which equals 0.050003, or 5.0003 percent. The BNAF of 5.0003 percent reflects a 25 percent reduction in the full BNAF. The 25 percent reduction in the BNAF of 5.0003 percent would be applied to the raw pre-floor, pre-reclassified hospital wage index values of 0.8 or greater used in the published FY 2008 hospice wage index.

The hospice floor calculation will still apply to any raw pre-floor, pre-reclassified hospital wage index values less than 0.8. Currently, the floor calculation has 4 steps—(1) Raw pre-floor, pre-reclassified hospital wage index values that are less than 0.8 are first multiplied by 1.15; (2) the minimum of 0.8 or the raw pre-floor, pre-reclassified hospital wage index value times 1.15 is chosen as the preliminary hospice wage index value; (3) the raw pre-floor, pre-reclassified hospital wage index value is multiplied by BNAF; and (4) the greater result of either step 2 or step 3 is chosen as the final hospice wage index value. We left the hospice floor calculation unchanged, noting that steps 3 and 4 will become unnecessary once the BNAF is eliminated.

For the simulations of the BNAF phase-out for FY 2010 and FY 2011, we used the same raw pre-floor, pre-reclassified hospital wage index values and claims data as the example above, and simply changed the value of the BNAF to reflect either a 75 percent reduction for FY 2010 or a 100 percent reduction for FY 2011. In both cases we started with the full BNAF of 6.6671 percent. We changed the calculation to take 25 percent of the full BNAF to reflect a 75 percent reduction for FY 2010, or eliminated the BNAF altogether to reflect a 100 percent reduction for FY 2011. For FY 2010, the reduced BNAF or the hospice floor was then applied to the 2007 raw pre-floor, pre-reclassified hospital wage index as described previously. For FY 2011 and subsequent years, the raw pre-floor, pre-reclassified hospital wage index values would be unadjusted unless they are less than 0.8, in which case the hospice floor calculation would be applied. Again, we note that the steps in the calculation that involve the BNAF will become unnecessary once the BNAF is phased out.

For our simulations, the calculations of the BNAF are as follows:

- A 75 percent reduction to the BNAF in FY 2010 would be $0.066671 \times 0.25 = 0.016668$ or 1.6668 percent.
- A 100 percent reduction or elimination of the BNAF in FY 2011 would be $0.066671 \times 0.0 = 0.0$ or 0 percent.

We examined the effects of phasing-out the BNAF versus using the full BNAF of 6.6671 percent on the FY 2008 hospice wage index. The FY 2009 BNAF reduction of 25 percent resulted in approximately a 1.55 to 1.57 percent reduction in the hospice wage index values. The FY 2010 BNAF reduction of 75 percent would result in an estimated additional 3.12 to 3.13 percent reduction from the FY 2009 hospice wage index values. The elimination of the BNAF in FY 2011 would result in an estimated final reduction of the FY 2011 hospice wage index values of approximately 1.55 to 1.57 percent compared to FY 2010 hospice wage index values.

Those CBSAs whose raw pre-floor, pre-reclassified hospital wage index values had the hospice floor calculation applied before any change to the BNAF would not be affected by the phase-out of the BNAF. These CBSAs, which typically include rural areas, are protected by the hospice floor calculation. Additionally, those CBSAs, which were eligible for the hospice floor calculation, but whose hospice wage index values were previously 0.8 or greater after the calculation was applied, but which would have values less than 0.8 after the calculation using a reduced BNAF was applied, would see a smaller reduction in their hospice wage index values. We have estimated the number of CBSAs that would have their raw pre-floor, pre-reclassified hospital wage index value eligible for the floor calculation after applying the 25, 75, and 100 percent reductions in the BNAF. Three CBSAs would be affected by the 25 percent reduction, 12 would be affected by the 75 percent reduction, and 22 would be affected by the 100 percent reduction. Because of the protection given by the hospice floor calculation, these CBSAs would see smaller percentage decreases in their hospice wage index values than those CBSAs that are not eligible for the floor calculation. This will benefit those hospices with lower hospice wage index values, which are typically in rural areas.

Finally, the hospice wage index values only apply to the labor portion of the payment rates; the labor portion was described in section I.B.1 of the proposed rule (73 FR 24002). Therefore, the estimated reduction in payments due to the phase-out of the BNAF would be less than the percentage reductions to the hospice wage index values that would result from reducing or eliminating the BNAF. In addition, the effects of the phase-out of the BNAF will also be mitigated by a hospital market basket update in payments, which in FY 2008 was a 3.3 percent increase in payment rates. The hospital market basket update for FY 2009 will be 3.6 percent. This update and the FY 2009 payment rates will be officially communicated through an administrative instruction and not through rulemaking. The estimated effects on payment described in column 5 of Table 2 in section V of this final rule include the projected effect of a FY 2009 3.6 percent hospital market basket update.

b. Effects of Phasing Out the BNAF Using the Updated Raw Pre-Floor, Pre-Reclassified Hospital Wage Index Data (FY 2009 Proposal)

In this final rule, for FY 2009, we are updating the hospice wage index using the 2008 raw pre-floor, pre-reclassified hospital wage index and the most complete claims data available (FY 2007 claims as of March 2008). Using these data, we computed a full BNAF of 6.6255 percent. For the first year of the BNAF phase-out (FY 2009), the BNAF will be reduced by 25 percent, or $0.066255 \times 0.75 = 0.049691$, to 4.9691 percent. This will decrease hospice wage index values by approximately 1.55 to 1.56 percent from wage index values with the full BNAF applied. As noted in the previous discussion on the effects of the BNAF reduction in the published FY 2008 hospice wage index, those CBSAs which already have raw

pre-floor, pre-reclassified hospital wage index values that have the hospice floor applied before implementing a BNAF reduction will be completely unaffected by this BNAF reduction (for example, rural West Virginia, and CBSA 13900, Bismarck, ND). Those CBSAs which are eligible for the hospice floor, and which previously had hospice wage index values above 0.8 after applying the full BNAF (as part of the floor calculation), but which now are below 0.8 with the 25 percent reduction in the BNAF, will be less affected by the BNAF reduction than those CBSAs which are 0.8 or above after applying the BNAF. They are protected by the hospice floor calculation (for example, rural Alabama would realize a decrease in its wage index value of only 0.40 percent, and CBSA 27780, Johnstown, PA, would realize a decrease in its wage index value of only 0.53 percent). Additionally, the final hospice wage index is only applied to the labor portion of the payment rates, so the actual effect on estimated payment will be less than the anticipated percent reduction in the hospice wage index value. Furthermore, that effect will be mitigated by a market basket update. The final market basket update for FY 2009 will be 3.6 percent rather than the 3.0 percent estimated in the proposed rule.

Column 3 of Table 2 (section V of this final rule) shows the impact of using the most recent wage index data (the 2008 raw pre-floor, pre-reclassified hospital wage index not including any reclassification under section 1886(d)(8)(B) of the Act) compared to the 2007 raw pre-floor, pre-reclassified hospital wage index data which was used to derive the FY 2008 hospice wage index. Column 4 of Table 2 in Section V of this final rule shows the impact of incorporating the 25 percent reduction in the BNAF in the FY 2009 hospice wage index along with using the most recent wage index data (2008 raw pre-floor, pre-reclassified hospital wage index). Finally, column 5 of Table 2 shows the combined effects of using the updated raw pre-floor, pre-reclassified hospital wage index, the 25 percent reduced BNAF, and a FY 2009 market basket update of 3.6 percent. The FY 2009 rural and urban hospice wage indexes can be found in Addenda A and B of this final rule. The raw pre-floor, pre-reclassified hospital wage index values were adjusted by the 25 percent reduced BNAF or by the hospice floor.

Comment: Many commenters stated that the impact of the phased elimination of the budget neutrality provision is much greater than the 1.1 percent reduction in payment that was described in the proposed rule. These commenters stated that some providers will experience reductions ranging from 5 percent to in excess of 14 percent over the 3 years as a result of the BNAF phase-out, and stated that the cuts would create hardship for hospices. Several commenters gave specific examples of CBSAs where wage index values decreased more than 1.1 percent, or of wage index values in contiguous CBSAs which decreased, but by differing amounts. The commenters stated that they cannot match pay scales with such a disparity in wage index values, and that there are no differences in medical costs between adjoining CBSAs.

Response: We appreciate the comments about the financial impact of the proposed rule, but are very concerned that incorrect percentage impacts on payments from the BNAF reduction are being cited in many of the comments. Some commenters may have confused the effect of the BNAF reduction with the effect of fluctuations in the wage index values from the raw pre-floor, pre-reclassified hospital wage index. This hospital wage index is used to derive the hospice wage index. We emphasize that the BNAF reduction will result in a payment reduction to hospices of no more than 1.1 percent in FY 2009. The large payment cuts which hospices repeatedly cited are not due to the BNAF reduction. The impact table in the proposed rule shows the effects of using the updated wage index values, the combined effects of using updated wage index values and the 25 percent reduction in the BNAF, and the combined effects of the updated wage index values, the 25 percent BNAF reduction, and the market basket update. Given the apparent confusion, we will clarify our methodology for calculating the FY 2009 hospice wage index to include the BNAF reduction, and we will expand our explanation of the associated impacts.

In the proposed rule, using the most current data available, we first calculated the unreduced BNAF for FY 2009, which was 6.5357 percent. We reduced that number by 25 percent, to arrive at 4.9018 percent. The raw wage index values from the raw pre-floor, pre-reclassified hospital wage index were increased by 4.9018 percent instead of by 6.5357 percent for every CBSA or rural area with a wage index value of 0.8 or greater (if the raw wage index value was less than 0.8, the hospice floor applied). The difference in the wage index value was 6.5357 percent − 4.9018 percent = 1.6339 percent. However, the wage index value only applies to the labor portion of payments, so the effect on payments is less. The labor percentages do not vary by hospice or by CBSA; they are the same for every provider. Therefore the impact of the BNAF reduction on payments does not and cannot vary from one location to another.

In the proposed rule, our impacts showed the effect of the 25 percent BNAF reduction (not including the effect of using the updated wage index) on total payments to be a 1.0 percent reduction (1.1 percent in this final rule), compared to what hospices would have received if the full BNAF had been used. We noted in the proposed rule that this reduction would be offset by a market basket update that was estimated at 3.0 percent. Because the BNAF reduction is applied across the board to the raw pre-floor, pre-reclassified hospital wage index values as a percentage reduction, all hospices (except those subject to the floor) are affected the same in that this final rule's estimated reduction in payments to all hospices is approximately 1.1 percent. Over the course of the 3-year phase-out, the elimination of the BNAF will reduce payments by about 4 percent: We estimated a 1.1 percent reduction in FY 2009, an additional 2 percent reduction in FY 2010, and an additional 1 percent reduction in FY 2011. However those reductions do not include 3 years of market basket updates for FY 2009, FY 2010, and FY 2011. Therefore, assuming market basket updates' inclusion in FY 2010 and FY 2011, hospices will still have a net gain in payments over the 3 years. While we do not know what the market basket updates will be for FY 2010 and FY 2011, hospices received market basket updates ranging from 3.3 percent to 3.7 percent from FY 2005 to FY 2008. The market basket update for FY 2009 is 3.6 percent. Because we do not know how the commenters calculated the percentage reductions they cited, it is unclear whether they accounted for market basket updates in their analyses. Therefore, not knowing the details of the analysis, we are unable to comment further on, or substantiate, the commenters' analysis.

As with the estimated reduction for FY 2009, the reductions in FY 2010 and FY 2011 payments will apply uniformly to all hospices with wage index values ≥0.8. Therefore, for hospices with raw pre-floor, pre-reclassified hospital wage index values ≥0.8, the reductions over the 3 years will not be larger for one hospice versus another. As noted in the proposed rule, those with raw pre-floor, pre-reclassified wage index values <0.8 will be less affected or unaffected by the BNAF phase-out.

In this final rule, we calculated the BNAF using updated claims data (2007 claims as of March 2008). The full BNAF was slightly higher at 6.6255 percent; the 25 percent reduced BNAF was 4.9691 percent, which is slightly higher than the BNAF in the proposed rule. Therefore, the raw pre-floor, pre-reclassified hospital wage index values used to derive the hospice wage index were increased by 4.9691. Because of the increase in the BNAF itself from the proposed rule to the final rule, the hospice wage index values in this final rule are slightly higher than those that were in the proposed rule.

Additionally, the final market basket update for FY 2009 is 3.6 percent rather than the 3.0 percent estimated in the proposed rule. That means the total impact of using an updated wage index, of reducing the BNAF by 25 percent, and of the market basket update is estimated to be a 2.5 percent increase in payments to hospices in FY 2009.

The impact of the BNAF reduction does not vary from hospice to hospice (except for those subject to the floor) as the same adjustment was applied across the board to the raw pre-floor, pre-reclassified hospital wage index values. Likewise, the impact of the market basket update does not vary from hospice to hospice, as the 3.6 percent increase is applied to the same base rates across the board. Therefore our impacts do not and cannot mask the effects of the BNAF reduction by presenting aggregate data.

The only place for variation in payment at the individual hospice level is within the raw pre-floor, pre-reclassified hospital wage index values themselves. These raw wage index values are the input values which are adjusted by either the BNAF or the hospice floor calculation to derive the hospice wage index. To show the changes from FY 2008 to FY 2009 in the raw pre-floor, pre-reclassified hospital wage index, from which the hospice wage index is derived, see Addendum C in this final rule.

Addendum C shows that large fluctuations in some wage index values exist from year to year, some positive and some negative. These fluctuations are the source of negative and positive effects on payment to hospices beyond the 1.1 percent reduction due to the BNAF and the 3.6 percent increase due to the market basket update. Between FY 2008 and FY 2009, there were 21 CBSAs or rural areas with raw pre-floor, pre-reclassified hospital wage index values which decreased 5 percent or more, and 16 CBSAs or rural areas with raw pre-floor, pre-reclassified hospital wage index values which increased 5 percent or more. We have also included Addendum D, comparing FY 2008 raw pre-floor, pre-reclassified hospital wage index values with those from FY 2007 to demonstrate that fluctuations in raw wage index values occur every year. Addendum D shows that there were actually more fluctuations between FY 2007 and FY 2008 than between FY 2008 and FY2009; Addendum D also shows that between FY 2007 and FY 2008, 23 CBSAs or rural areas had raw pre-floor, pre-reclassified hospital wage index values that decreased by 5 percent or more, and 17 CBSAs or rural areas that increased by 5 percent or more. We remind commenters that these raw pre-floor, pre-reclassified hospital wage index values are adjusted upward by the hospice floor if the value is below 0.8. These fluctuations do not translate into an equivalent increase or decrease in payments, as the wage index value only applies to the labor portion of payments. Additionally, in considering the total impact on payments, commenters would need to account for the market basket increase that applies to hospice payment rates.

The raw pre-floor, pre-reclassified hospital wage index originates from data provided on each hospital's cost reports. Hospitals must report their wages paid; Medicare takes those data for the hospitals in each CBSA and computes a CBSA average hourly rate. It also takes the data for all hospitals and computes a national average hourly rate, which becomes the standard. The raw pre-floor, pre-reclassified wage index values for each CBSA are computed by dividing the CBSA's average hourly rate by the national average hourly rate. Therefore, if a wage index value is increasing or decreasing, it is because hospital wages within that CBSA are increasing or decreasing relative to the national average.

CMS performs an intensive review of the hospital wage data, mostly through use of edits to identify aberrant data. The Fiscal Intermediary/MAC then revises or verifies the data elements that resulted in specific edit failures.

Table 1 below shows calculation of the hospice wage index for both FY 2008 and FY 2009, beginning with the raw pre-floor, pre-reclassified wage index value (the input), and applying the BNAF or hospice floor for 3 CBSAs. For the first CBSA (31020), the raw pre-floor/pre-reclassified hospital wage index for FY 2009 is greater than it was in FY 2008. Conversely, the raw pre-floor/pre-reclassified hospital wage index values for CBSAs 41780 and 48540 are less in FY 2009 than in FY 2008. Table 1 shows the computation of the hospice wage index values for these CBSAs for FY 2008 and for FY 2009 (using proposed rule BNAF values). The table also demonstrates that the hospice floor protects values <0.8 from the effects of the BNAF reduction. In this case (CBSA 48540), the FY 2009 proposed wage index value is unchanged from the final wage index value for FY 2008. Therefore, as we noted in the proposed rule, the BNAF reduction had no effect in this circumstance.

The cities and counties which make up CBSAs are not determined by CMS, but instead are set by the OMB. Information about CBSA designations is available at the following Web site: *http://www.whitehouse.gov/omb/bulletins/fy2008/b08-01.pdf*. We continue to believe that OMB's CBSA designations reflect the most recent available geographic classifications and are a reasonable and appropriate way to define geographic areas for the purposes of determining wage index values.

Currently there are limited data available for analysis of the impact of the phase-out of the BNAF on quality. The new claims data (with visit reporting beginning July 1st, 2008) and the new Conditions of Participation will provide data related to quality of care. We will monitor these data for any unanticipated effects of the BNAF phase-out.

TABLE 1—EXAMPLES OF HOW THE PROPOSED FY 2009 WAGE INDEX VALUES WERE DERIVED

CBSA	FY08 input—raw pre-floor pre-reclassified hospital wage index for FY08	FY 08 BNAF—Full BNAF = 0.066671 increases input value for all providers w/WI values ≥ 0.8; or apply hospice floor	Output—FY 2008 final hospice wage index value	FY09 input—raw pre-floor pre-reclassified hospital wage index for FY09	FY 09 proposed BNAF—25% reduced BNAF = 0.049018 increases input value for all providers w/WI values ≥ 0.8; or apply hospice floor	Output—FY 2009 NPRM hospice wage index value
31020	1.0011	× 1.066671	1.0678	1.0827	× 1.049018	1.1358
41780	0.9302	× 1.066671	0.9922	0.8822	× 1.049018	0.9254
		FY08 input < 0.8; hospice floor applies	.....	.....	FY09 input < 0.8; hospice floor applies	.....
		0.7010 × 1.15 = 0.8062; (Subject to 0.8000 max)	.....	.....	0.6961 × 1.15 = 0.8005; (Subject to 0.8000 max)	.....
		0.7010 × 1.066671 = 0.7477	.....	.....	0.6961 × 1.049018 = 0.7302	.....
48540	0.7010	Take greater of 15% increase (subject to 0.8 maximum) or BNAF increase	0.8000	0.6961	Take greater of 15% increase (subject to 0.8 maximum) or BNAF increase	0.8000

Comment: A number of commenters referred to the BNAF phase-out as a ''rate reduction'' or stated that CMS was cutting rates. In addition, a commenter asked CMS to publish the rate updates as part of the rule in the **Federal Register**, rather than in an administrative notice such as a Change Request.

Response: The BNAF is an adjustment which increases the raw pre-floor, pre-reclassified hospital wage index values that are 0.8 or greater, with the result being the hospice wage index. Raw pre-floor, pre-reclassified hospital wage index values <0.8 have the hospice floor calculation applied instead.

The hospice payment rates are per diems for routine home care, continuous home care, respite care, and general inpatient care. They were put into place by Congress, and are updated annually by the market basket update. We have not proposed any cut to the payment rates. In the proposed rule, we estimated that the per diems would increase due to a 3.0 percent market basket update; for the final FY 2009 rule the market basket update to be applied to the per diems increased to 3.6 percent. Therefore, we are not cutting hospice payment rates. Conversely, hospice payment rates for FY 2009 will be increased by the hospital market basket update of 3.6 percent, and will be communicated through a separate administrative instruction/issuance this summer.

We appreciate the comment about where payment rate updates are published. Historically, the payment rate updates have been issued through a separate administrative instruction or administrative issuance in the summer of each year to provide adequate time to implement the necessary system changes. In previous years, the hospice wage regulation was often published after August 1st, which does not allow sufficient time for system changes to be made to accommodate the October 1st implementation of payment updates. We will look into including the updated payment rates in the **Federal Register** in the future.

Comment: CMS received a number of comments suggesting that a BNAF phase-out would limit access to hospice care. Multiple commenters noted that costs were rising, including gasoline, wages, pharmacy costs, medical supplies, insurance, utilities, and food, and that hospices cannot absorb these costs in addition to the BNAF reduction without adversely affecting Medicare beneficiary hospice care. One commenter mentioned the high cost of converting to electronic health records. Many commenters stated that the BNAF reduction exacerbates the financial strain that CMS has already imposed on hospices this year, noting new hospice costs resulting from CMS's requirements to implement new Hospice Conditions of Participation (CoPs), and CMS's new visit data collection requirements (CR 5567). A few commenters stated that agencies are having difficulty soliciting donations in this economic downturn. Some rural providers commented that their staff may drive 100 miles each way to visit patients, and that they cannot afford the rising cost of gasoline. Rural and urban commenters stated that they could not survive a reduction in payments in the face of rising costs. These commenters stated that as a result of the BNAF reduction, they would have to limit the geographic areas they service, thus limiting hospice access to beneficiaries, especially in rural areas.

In addition, few commenters stated that there was anecdotal evidence that an increasing number of hospices had ceased operations or were in danger of closing, due to rising gas prices and to cap overpayments. Other commenters stated that they may have to delay expansion. Some commenters stated that they would have to discontinue programs, including bereavement programs, outreach programs, programs to specific underserved groups (for example, to inner city beneficiaries), complementary treatments (that is, acupuncture and art therapy) or comfort items such as overlay airflow mattresses, and charity care. Several commenters mentioned that hospices would be forced to limit access by restricting admissions, limiting the number of admissions for costly, medically complex patients such as cancer patients needing expensive palliative treatments. There was concern among many commenters that the BNAF phase-out would lead to cost-cutting within hospices, including staff reductions that would jeopardize quality patient care. Commenters stated that quality care takes time, but if staffing is reduced, the nurse-to-patient ratio will be unfavorable, and hospice workers will spend less time with patients. One commenter stated that hospices may cut the number of visits they make, and use phone contact instead. Another stated that the reduction disproportionately punishes best practices which hold true to the hospice concept. A commenter felt that the BNAF reduction punishes high quality, high quantity providers.

Response: We appreciate the commenters' concerns about rising costs and about access to hospice care. We agree that costs are rising and that it is vital to preserve access to hospice care for Medicare beneficiaries. As noted in our response to a previous comment, it appears that the changes in payments to individual hospices have been

misunderstood as being due to the BNAF reduction. For FY 2009, the BNAF reduction cannot affect any hospice by more than 1.1 percent. As stated in an earlier response, it is worth noting that while it is true that, in a given year, some areas will see what could be considered a significant decrease in their raw pre-floor, pre-reclassified hospital wage index value, other areas will see significant increases in their raw pre-floor, pre-reclassified hospital wage index value. These fluctuations in the raw pre-floor, pre-reclassified hospital wage index occur every year (Addenda C and D of this final rule show fluctuations from FY 2007 to FY 2008 and from FY 2008 to FY 2009). These fluctuations are not related to the BNAF reduction, and we believe the 1.1 percent impact of the BNAF, which is offset by the 3.6 percent FY 2009 market basket update, will not force hospices to close their doors or otherwise affect access to the quality, compassionate care which beneficiaries expect and deserve.

We agree that rising gas prices are a concern for hospices, and note that the hospital market basket update which is used by hospices includes an energy component that is sensitive to petroleum costs. It is reasonable to expect that future market basket updates will continue to account for any continuation of rising fuel costs. The FY 2009 market basket update increased from 3.0 percent in the proposed rule to 3.6 percent in this final rule, partly due to rising energy costs. We refer the reader to the comment about the market basket update later in this section for more details on the market basket update.

In addition, we believe that the requirements associated with the CoPs and CR5567 are part of the cost of doing business, and that the industry has had ample time to plan and budget for these changes. We do not believe that these requirements will have adverse affects on admissions or services, but instead expect that the emphasis on quality and the increased awareness of visits provided could enhance services.

We believe that in a time of inflationary pressure, all businesses, including hospices, will seek to operate more efficiently. We do not believe that the BNAF reduction will lead to the type of cost-cutting that would jeopardize quality care. However, we plan to monitor the effect of the BNAF reduction to assess whether unanticipated effects occur.

Comment: Several commenters mentioned the Medicare Payment Advisory Commission's (MedPAC's) June 2008 report which includes a discussion of hospice margins. Commenters stated that MedPAC reports hospice margins for the period 2001 through 2005 averaged 3.4 percent, and margins for some categories of providers were even lower. For example, commenters stated that MedPAC reported margins for not-for-profit hospices that were −2.8 percent during this period. Commenters stated that hospices cannot withstand the payment reductions resulting from the BNAF phase-out, stating that complete elimination of the BNAF would result in negative margins for all hospice provider types. Commenters were especially concerned about the effect any BNAF reduction would have on not-for-profit hospices, stating that the reduction will further reduce margins which are already in the negative range. Commenters were concerned that the BNAF reduction will reduce profitability and increases losses such that hospices will close.

Response: In June 2008, MedPAC published a report entitled ''Evaluating Medicare's Hospice Benefit'' (MedPAC, pp. 203–237). This is the first time margins have been analyzed for hospices. MedPAC estimated Medicare hospice margins using Medicare claims and cost report data for the period from 2001 to 2005. Their report stated, ''These margins may not provide a full picture of hospices' financial status. Nonprofit hospices derive revenues from philanthropic donations, which are an integral part of their operations and mission; these revenues are not consistently reported on Medicare cost reports. These revenues may help offset the generally negative margins we observe for nonprofit hospice providers. Additionally * * * hospitals may find it desirable to operate hospices, even in light of negative hospice margins. Harrison and colleagues (2005) found that hospitals that operated hospice programs had higher return on assets and higher hospital occupancy rates, as well as shorter lengths of stay, than hospitals without hospices'' (MedPAC, p. 224).

As noted above, the margins that MedPAC showed in its report may not tell the full story of hospice profitability. MedPAC noted that financial analysts have estimated margins of 6 to 15 percent for 2006 for the 3 largest publicly traded hospice chains. Further, MedPAC noted that Security and Exchange Commission (SEC) filings on publicly traded hospices estimated margins based on all revenues and costs (not just Medicare, which accounts for more than 90 percent hospice revenues). Two major for-profit chains had 7 percent and 7.8 percent margins in CY 2006. A third chain showed a loss of 3 percent for FY 2007, but attributed it partly to corporate restructuring costs and their cap liability (they have since reduced their cap exposure). MedPAC noted that the chain with the 7.8 percent margin was seeking to acquire the chain with the loss. In addition, analysts project that the prospective buyer's margins will be 11 to 12 percent over the next several years.

We will continue to work with MedPAC to assess the appropriateness of future enhancements to the Hospice payment system. We will work closely with them as they review and refine their margin analysis and assess the impact of the BNAF reduction on margins. Phasing out the BNAF rather than eliminating it all at once enables us to iteratively assess the impact of the reduction.

Comment: Many commenters wrote about the financial hardship to hospices as a result of rising fuel costs. Two commenters said they do not reimburse volunteers for mileage, and that they were losing volunteers because of high gasoline prices, with rural areas being particularly hard hit. Several providers, particularly rural ones, noted that their staff may drive 100 miles each way to see a patient or that their service area may cover over 1,000 square miles. A commenter also asked that we develop a hospice-specific reimbursement system that would entail developing a hospice-specific market basket. A commenter noted that the per diems are updated by an index which is not hospice specific, and that the assumptions in the per diem components had changed. Pharmacy costs, travel costs, and salaries have risen at rates that are not provided for in the subsequent market basket updates. Several noted that using the hospital market basket was disadvantageous to hospices because of differences in the way hospices and hospitals operate; some mentioned that hospice providers have been adversely impacted by the tremendous rise in gasoline prices far more than hospitals, because hospice services are provided where the patient resides rather than in a single facility. A commenter added that the market basket updates are not driven by an objective analysis of hospice costs.

Response: Section 1814(i)(1)(C)(ii)(I) of the Act requires that the hospice PPS market basket update factor be based on the IPPS hospital market basket (as defined in Section 1886(b)(3)(B)(iii) of the Act). The IPPS market basket reflects the operating cost structures of IPPS hospitals and the inflationary pressures

facing these providers. The market basket update factor includes any associated price changes with labor, energy, insurance, food, pharmacy, and other IPPS hospital operating costs.

Hospitals and hospice facilities both hire staff from the same healthcare worker labor pool; however, hospitals tend to have a higher skill occupation mix compared to hospice facilities. The IPPS market basket update factor reflects the inflationary pressures on these highly skilled healthcare occupations.

The hospice per diems are updated using the hospital market basket, which we agree is not hospice-specific. While the hospital market basket does not have a specific transportation factor, it does include energy costs. It also includes pharmacy costs and wage costs. To see the components in the hospital market basket, we refer the reader to: *http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/mktbskt-pps-hospital-2002.pdf.* To better understand the market baskets and how they are constructed, we also refer the reader to: *http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/info.pdf.*

Regarding the development of a hospice-specific market basket, CMS will investigate the cost structures specific to hospice facilities and how they compare to IPPS hospitals. However, we believe that Congress intended us to use the hospital market basket to adjust for hospice inflationary pressures, and therefore, the authority to create and use a hospice-specific market basket is determined by Congress.

Comment: Several commenters stated that there were likely to be major revisions to the hospital wage index in the future and that CMS should not remove the BNAF when the wage index is fluctuating. A few commenters indicated that CMS has not studied the impact on the hospice payment system of hospital wage index changes which occurred over the past 10 years. These commenters also stated that CMS justified the application of hospital-specific changes to the hospice payment system by application of the BNAF, which serves as a ''cushion'' for hospice. They also indicated that hospice providers were never given an opportunity to study the impact of these changes. Finally, these commenters stated that eliminating the BNAF now would subject hospices to multiple, significant changes over a short period of time. One commenter stated that CMS proposal to phase-out the BNAF is not reform. Another commenter indicated that wage index is as important to the stability of hospice care as are base payment rates, the annual inflation rate update, and the aggregate annual hospice cap, and suggested that stability would be lost if the BNAF were phased-out.

Furthermore, a commenter indicated that the current hospital-based wage index was not accurate, reliable, or equitable. The commenter stated that some hospices are part of health systems that have wage indices lower than a hospital in the same system and the same geographic area. Therefore, the commenter asserts, CMS cannot reason that the BNAF phase-out is needed for accuracy, reliability, and equity.

Response: In the May 1, 2008 proposed rule, we proposed phasing out the BNAF over 3 years because this adjustment has served its purpose, which was to mitigate the adverse financial impact of transitioning to a new wage index in 1998. The need for the BNAF has passed for a variety of reasons, as stated in section II.C.3 of this final rule. We did not propose to reform the raw pre-floor, pre-reclassified hospital wage index or the hospice payment system, but only to phase out the BNAF. We did not propose to phase out the hospice floor calculation, which continues to apply when raw pre-floor, pre-reclassified hospital wage index values are < 0.8, though we noted that the steps involving the BNAF would become unnecessary once the phase-out is complete.

The raw pre-floor, pre-reclassified hospital wage index is the same wage index used by the other home-based Medicare benefit, home health, which draws from the same labor pool as hospices. Home health agencies experience the same wage index fluctuations, but do not receive an adjustment such as the BNAF; therefore, we do not believe that phasing out the hospice BNAF in the presence of normal wage index fluctuation will be detrimental to the industry or threaten stability.

Our purpose in phasing out the BNAF is not to reform the wage index, but rather to phase out an adjustment which served its purpose. The BNAF helped hospices adjust to the negative financial impact of changing from the Bureau of Labor Statistics-based wage index to the raw pre-floor, pre-reclassified hospital wage index. There is no longer a need for this adjustment given that the transition occurred over 10 years ago and the growth that has occurred in the industry.

In our proposed rule, we stated that one reason for phasing out the BNAF is that it is not as accurate, reliable, and equitable as possible in accounting for geographic variation. The BNAF ties payments back to an outdated 1981 BLS-based wage index that the Negotiated Rulemaking Committee called ''inaccurate'' in its Committee Statement (62 FR 42883). We are unable to respond to the comment about one health system's wage index being different from that of a hospital in the same area as it is outside the scope of this rule.

Comment: One commenter suggested that CMS conduct a study to determine the appropriate per diems for rural hospices, asserting that rural costs are not adequately addressed in the current payment system. This commenter suggested CMS include an additional time and distance factor for rural hospices to align the per diem with rural costs.

Response: Medicare pays one of four daily rates to hospice providers, based on the intensity level of care the patient requires. These per diem payment rates are the same, regardless of whether the services are provided in an urban area or a rural area. The hospice wage index, which includes a floor calculation which benefits many rural providers, is the vehicle we use to adjust for geographic variances in labor costs. In a time of high gasoline costs, we are sensitive to concerns from rural hospices that the additional time and distance required to visit a rural patient adds significantly to their costs, and their assertion that payments are not adequate. However, we believe that an additional payment for rural providers, which is sometimes called a rural add-on payment, would have to be legislated.

Comment: Several commenters indicated that hospices sometimes care for high cost patients such as those who require more expensive palliative radiation or chemotherapy, and that hospice reimbursements are not sufficient to provide quality care to these complex patients. Another commenter stated that the original hospice per diems were arbitrarily set by CMS (formally HCFA) and had to be raised by Congress. A commenter stated that increased case mix and new treatment options have also affected hospice costs. A commenter recommended that CMS study the real costs of hospice care and devise a 21st century, hospice-specific reimbursement system. One commenter recommended that CMS raise the wage-related per diem.

Several commenters asked CMS not to decrease payments because they are already providing services above the level of reimbursement that is presently provided in the daily rate. Another

commenter stated that Medicare does not pay for staff consultations, pre-admission consults, travel time to patients' homes, or the cost of fuel. A few commenters stated that hospices now provide an ever-expanding array of costly palliative treatments.

Response: While these comments addressed issues that are beyond the scope of this final rule because they concern issues about which we did not make any proposals, we will address them briefly since they pertain to overall hospice reimbursement. In its June 2008 report, MedPAC wrote that hospice payments are generally adequate in the aggregate, but noted that individual hospices' performance varies (MedPAC, p. 205).

The hospice per diems were designed to cover hospice costs and were developed based on cost information gathered from a demonstration project that began in October, 1980 and which included 26 hospices. The per diems include costs of the services hospices provide, plus overhead costs such as maintenance, depreciation, general accounting, capital, and other administrative costs in the calculation of the individual service components (that is, nursing services and aide services). A cost component is included for hospital outpatient charges for palliative radiation and chemotherapy, based on a sample of Medicare patients who died from cancer in 1980, and adjusted for inflation. In the future, we plan to perform analyses on hospice resource utilization, in the hopes of refining our hospice payment system. We will consider the high cost of certain palliative treatments in future payment refinements analyses.

As some commenters stated there have been changes in hospice case mix, with proportionally fewer cancer patients and more patients with other diagnoses such as dementia and congestive heart failure. At this time, we do not have the data on services provided to patients with specific diagnoses, and therefore cannot easily determine the adequacy of Medicare payments relative to the cost of care. However, hospices were required to begin reporting visits for nurses, physicians, social workers, and aides as of July 1, 2008 (This is just a beginning in data collection efforts that should provide the information needed to refine payments in the future). We note that because hospice rates are currently described in statute, any hospice payment refinements which affect those rates would need to be enacted by Congress.

Comment: Many commenters praised the benefits of hospice, which provides care to the most vulnerable Medicare beneficiaries for example, the dying and does so in a cost-effective fashion that saves Medicare money. They suggested that if hospice utilization declines, beneficiaries would be forced to use more costly medical care, driving up Medicare costs in the long run. Others commented on the quality, compassionate care and comfort that hospice provides to patients and their families. Another commenter stated that hospice provides tremendous aid at end of life, serving the dying equally, regardless of color and economic status. These commenters and others asked that CMS not reduce payments. Several commenters also questioned the timing of CMS' proposal to eliminate the BNAF. They felt CMS should not be cutting hospice benefits at a time when the demand for services is growing. One commenter stated that the industry growth is a testament to the service gap that hospice fills, the growing awareness of hospice, and preference for a hospice death. A few mentioned that CMS has encouraged hospice usage. One commenter indicated that studies show that patients live longer on hospice, but there is still a need for earlier referrals to the benefit. The commenters stated that the population is aging and the baby boomer generation is getting older.

Response: We agree that the Medicare hospice benefit has been of tremendous benefit to those at end-of-life and to their families, and applaud those who serve the dying as hospice staff and volunteers. We also agree that the hospice benefit often saves Medicare money, and appreciate the studies which have highlighted the areas where it provides costs savings to the Medicare program. However, hospice care does not save money in every instance. MedPAC has noted that ''hospice's net reduction in Medicare spending decreases the longer the patient is enrolled and beneficiaries with very long hospice stays may incur higher Medicare spending than those who do not elect hospice.'' (MedPAC, p. 209). We do not believe that hospice utilization will decline due to the BNAF phase-out, and therefore, do not believe that Medicare costs will be shifted from hospice to more expensive forms of care. As noted in our response to a previous comment, the FY 2009 impact of the BNAF phase-out is, at most, 1.1 percent for every provider, and is being offset by a 3.6 percent FY 2009 market basket update, resulting in a 2.5 percent increase in payments to hospice providers in FY 2009.

We agree that the hospice industry is growing and that the demand for hospice services is likely to grow in the future, particularly with an aging population. We also agree that CMS has encouraged hospice usage. We have not cut Medicare hospice benefits in any way—terminally ill Medicare patients are still eligible to receive the same quality, compassionate end-of-life care that has been the hallmark of hospice. We expect the hospice benefit to continue to grow: CMS' Office of the Actuary projects that Medicare hospice spending will more than double in the next 10 years. However, we will monitor the impact of the BNAF phase-out for any unintended impact.

Comment: Several commenters recommended that CMS delay any BNAF reduction or phase-out. They suggested waiting for better and more reliable data, for time to evaluate the impact of the requirements from the new Conditions of Participation and from CR 5567. A commenter stated that CMS lacks the data to conduct a reasoned analysis, citing MedPAC's June 2008 report which stated that CMS needs substantially more data. One commenter recommended that CMS consider a 1-year freeze on any reductions and wait for more available data. Another commenter recommended that CMS delay until we had gathered data on the potential impact on hospice operations and quality of care of eliminating the BNAF. A commenter stated that there was not enough time to prepare for a change due to a BNAF phase-out. Other commenters asked CMS to wait until MedPAC completes its hospice analysis and CMS updates its hospice payment system, before eliminating the BNAF. Several other commenters recommended phasing out the BNAF more gradually. Some recommended a gradual phase-out that would help minimize the economic impact of such a change, particularly at a time of rising gas prices. One commenter recommended a 5-year phase-out, and another recommended a 7-year phase-out, with a 25 percent reduction in FY 2009, a 15 percent reduction in FY 2010, and a 10 percent reduction through FY 2016. Another commenter recommended that implementing the BNAF reduction on a more gradual schedule would allow hospices time to evaluate the impact of the reduction of the new CoPs, hospital versus hospice costs, and of the June 2008 MedPAC report. Even with the proposed schedule for reducing, and ultimately eliminating the BNAF, commenters suggested that by CMS not providing impacts for the 2nd and 3rd year of reducing the BNAF, the industry was not afforded information as to the impact on hospices beyond the

proposed first year's reduction of the BNAF.

Response: We appreciate the commenters' input. However, we continue to believe that our phase-out approach as described in the proposed rule is appropriate. One reason we decided to implement a phased-out approach to reducing the BNAF was to ensure we would have the ability to assess the impact of the BNAF reduction iteratively. We plan to monitor the impact of the BNAF reduction for unintended effects. The financial impact of the phase-out is very clear; in FY 2009 it is estimated to affect hospices by no more than negative 1.1 percent. We continue to believe that because the FY 2009 market basket update is 3.6 percent, and hospices will receive 2.5 percent more in payments in FY 2009 than they received in FY 2008, the FY 2009 reduction should not have an adverse impact on hospice operations or quality.

The hospice CoPs were developed with input from the industry. The CoPs have been in development for 9 years and have widespread support from the industry. Hospices have been expecting these since the Conditions of Participation proposed rule was published in May of 2005, providing time to plan and budget for these changes accordingly. Hospices were required to report certain visit data as of July 1, 2008. This requirement was implemented through CR 5567 after MedPAC, the General Accounting Office, and the Office of the Inspector General recommended that CMS gather data on Medicare hospice service utilization. While the most recent revision of CR 5567 occurred on April 29, 2008, the initial issuance of the CR occurred on July 20, 2007, providing ample time for hospices to plan and budget for these requirements. CR 5567 requires reporting of visit data that many hospice software programs already track. We do not feel it will cause undue burden, especially since we recently revised the CR 5567 requirements to suspend a subset of the reporting requirements to address an industry concern. Additionally, we believe the industry has ample time to prepare for the BNAF phase-out. The FY 2009 President's budget was published in February, 2008 and contained a provision to phase out the BNAF. In the interest of transparency, we made public our intent to propose the BNAF reduction via FY 2009 rulemaking shortly after publication of the budget, over 2 months in advance of our proposed rule publication.

We agree that MedPAC recommended that CMS collect additional data to better understand what services we are paying for, and for use in future payment refinements. We did not propose to reform the payment system, but simply to remove an outdated adjustment.

We acknowledge that the impacts reflected in this rule are for FY 2009 only. The purpose of this final rule, so far as impacts, is to show the estimated impacts on hospice providers for FY 2009. We have, in the proposed rule (72 FR 24005, 24006) and in a response to a previous comment, communicated that over the course of the three-year phase-out, the elimination of the BNAF will reduce payments by about 4 percent: We estimated a 1.1 percent reduction in FY 2009, an additional 2 percent reduction for a cumulative reduction of 3.1 percent in FY 2010, and an additional 1 percent reduction for a cumulative reduction of 4.1 percent in FY 2011. However those reductions do not include 3 years of market basket updates for FY 2009, FY 2010, and FY 2011. Therefore, assuming market basket updates' inclusion in FY 2010 and FY 2011, hospices will still have a net gain in payments over the 3 years. While we do not know what the market basket updates will be for FY 2010 and FY 2011, hospices received market basket updates ranging from 3.3 percent to 3.7 percent from FY 2005 to FY 2008. The market basket update for FY 2009 is 3.6 percent. We will provide similar impacts for FY 2010 and FY 2011 in future rulemaking.

For all of these reasons, we do not feel that there is a reason to delay the phase-out of an outdated adjustment. While we believe that a 3-year phase-out is fair and appropriate, we will monitor the effects of the phase-out as it occurs.

Comment: A commenter wrote that hospitals and home health agencies receive the BNAF. The commenter said that since hospices compete with home health agencies and hospitals for staff, phasing out the BNAF for hospice creates an uneven playing field for recruiting and retaining staff. A few commenters stated that CMS should not justify removing the BNAF so that the hospice and home health wage indices were consistent. One commenter stated that the new CoPs recognized the differences between hospice and home care patients, noting that hospice patients are more fragile. Additionally, other aspects of the hospice and home health payment systems differ. These commenters indicated that the rules regarding hospice payment should remain unique, and do not need to mirror those for home health.

Response: We agree that there should be a level playing field for recruiting and retaining staff for home-based benefits such as hospice and home health. As we described in our proposed rule, because hospices and home health agencies share labor pools, we believe that there should be consistency in the wage index used by both these home-based benefits. Nothing in our data analysis has shown us that hospice labor costs differ substantially from home health labor costs, making it difficult to justify a 6 percent increase in the hospice wage index. We continue to believe that the raw pre-floor, pre-reclassified hospital wage index provides a good measure to account for geographic variances in labor costs for both these home-based benefits. Phasing-out the BNAF enables us to achieve this consistency.

The other commenters noted the differences between services provided in hospice care and home health care, citing the hospice CoPs. We agree that hospice patients can be more fragile and that hospice care is unique, and it is appropriate for hospice and home health to have different payment systems. However, the purpose of a wage index is to account for geographic variances in labor costs. We believe that the use of a consistent wage index in both these home-based benefits enables hospices and home health agencies to compete for staff on a level playing field.

Comment: One commenter stated that hospice reimbursement does not consider the higher cost of hospice care in the home versus in a nursing home. Hospice patients in the home require more staff visits, increased on-call expense, and increased mileage expense. The commenter stated that hospice patients in nursing homes do not need the same intensity of care as hospice patients who are residing in their own homes.

Response: While these comments address issues that are beyond the scope of this final rule, we will address them briefly since they generally relate to hospice reimbursement. The hospice benefit was designed as a home-based benefit, and the per diems were set up assuming that most care was routine care given in the home. Rather than considering the per diem inadequate because home care is more costly, we view the per diem as adequate for home care but possibly more than adequate for hospice patients residing in a nursing home. The routine home care per diem was built assuming costs for aides, and hospices do not have to provide the personal care that aides normally give to their patients who reside in nursing homes, because the nursing home staff is required to provide that care.

Likewise, if the hospice has multiple patients in the same nursing home, then hospice patients in nursing homes are less costly in terms of mileage and driving time. Hospice patients in nursing homes may require an equal intensity of service as patients in the home, and hospices should be prepared to provide all necessary services for their patients who reside in nursing homes.

Comment: A few commenters felt that CMS had not provided the sufficient data analysis to justify the elimination of the BNAF. They felt CMS's decision to eliminate it was arbitrary and capricious, and recommended that CMS withdraw the proposal. A few commenters stated that CMS did not follow the Administrative Procedures Act in proposing the BNAF phase-out. Another commenter stated that CMS advanced the proposal to phase out the BNAF because it offers the potential for reducing hospice payments quickly, to meet short term budget goals, without the need to collect and analyze data.

Response: We believe we complied fully with the Administrative Procedures Act in proposing to phase out the BNAF, by fully describing our proposals and rationale for our proposals, by providing the full impact of the proposal, and by providing opportunity for public comment. The effect of the BNAF is clearly illustrated in the impact analysis presented in the proposed rule, and in the updated impacts presented in this final rule. For FY 2009, the BNAF will not affect any hospice's estimated payments by more than 1.1 percent, and either has no effect on hospices with raw pre-floor, pre-reclassified wage index values <0.8, or affects them less than 1.1 percent. We believe that through misunderstanding, some in the hospice industry have shifted the focus of the impacts from the BNAF phase-out to the impact of fluctuations which occur in the raw pre-floor, pre-reclassified hospital wage index every year. We have added Addenda C and D to show the hospital-based wage index fluctuations for the last 2 years to demonstrate that they are a regular occurrence, and that there are fewer fluctuations from the prior year in FY 2009 than in FY 2008.

We believe the rationale for phasing out the BNAF which we discussed in the proposed rule (72 FR 24006), highlights data that justify our adoption of our proposal. Specifically, we described our analysis which we believe shows that the negotiating committee adopted the BNAF to mitigate the negative financial impact of the 1998 hospice wage index change. Our rationale in the proposed rule also describes our analysis of the growth in aggregate expenditures, the growth surge in the number of for-profit hospices, and the growth in the beneficiaries served that has occurred during the last decade. Our rationale also indicates a desire for parity between hospices and home health agencies since nothing in our data analyses indicates that hospice labor costs differ substantially from home health labor costs. We believe that these data, in conjunction with the impact analysis, show that this unique methodology for achieving wage index budget neutrality has served its purpose and is no longer necessary. We will continue to monitor the impact of the BNAF phase-out for any unanticipated effects.

Comment: A commenter stated that the BNAF phase-out discriminates against rural providers.

Response: We disagree that the BNAF phase-out discriminates against rural providers. As noted in our impacts, providers with raw pre-floor, pre-reclassified hospital wage index values of 0.8 or more are affected equally. These providers are estimated to experience a 1.1 percent reduction in payments in FY 2009. Providers with raw pre-floor, pre-reclassified wage index values <0.8 are protected by the hospice floor calculation and will either be less affected, or totally unaffected by the BNAF phase-out. Since many rural providers have lower raw pre-floor, pre-reclassified hospital wage index values, and therefore are eligible for the hospice floor calculation, we disagree that those rural providers eligible for the floor are actually less impacted on net.

Comment: A commenter stated that CMS was ''phasing out of the hospice wage index''.

Response: We appreciate this comment, as it provides the opportunity to clear up a misunderstanding. We are not phasing out the wage index, but rather are phasing out the BNAF, which is an adjustment that increases the wage index values.

Comment: A commenter stated that CMS is focusing on that small percentage of hospices that have long lengths of stay and a surplus of reimbursement over expense.

Response: The BNAF reduction is applied equally to every wage index value not subject to the hospice floor. It does not disproportionately affect hospices with long lengths of stay or with high margins. While there were good reasons for putting the adjustment into place, those reasons are no longer valid (see the proposed rule (72 FR 24006) for a discussion of the rationale behind phasing out the BNAF).

Comment: A few commenters stated that Congress has rejected the Administration's request to reduce the hospice reimbursement rate, understanding correctly that any reduction in rate must necessarily reduce either quality of care or access to care.

Response: We are unclear about what the commenter is referring to. Congress has reduced hospice reimbursements in the past, cutting market basket updates by as much as 2.5 percent.

Comment: A commenter stated that the budget neutrality does not take into account the market basket update.

Response: We appreciate this comment, as it allows us to clarify the above statement. The calculation to derive the BNAF takes the market basket update into account as it uses updated payment rates to calculate aggregate payments. Since we calculate aggregate payments using the same payment rates and the same utilization, and only vary the wage index used (the 1983 BLS-based wage index or the current raw pre-floor, pre-reclassified hospital wage index), the market basket update has no effect on the BNAF that results.

Comment: A commenter recommended that CMS consider an alternative to the BNAF phase-out. The commenter recommended that CMS establish minimum staffing patterns, as a better staffing ratio would lead to a reduction in patient pain, symptom crises, after-hours calls, 911 calls, trips to the emergency room, and revocations. In addition, the commenter stated that it would reduce staff turnover and improve retention.

Response: We thank the commenter for this recommendation. The new data reporting requirements from CR 5567, which began July 1, 2008, will enable us to investigate staffing patterns as part of any future hospice payment refinements analysis. However, we are not considering establishing minimum staffing patterns as an alternative to the BNAF phase-out.

Comment: A commenter stated that reporting for CR 5567 does not include all disciplines. In addition, the commenter stated that promoting quality hinges on recognizing differences between routine home care and hospice care, which CR 5567 seems to question. The episodic nature of home care lends itself to per-visit reimbursement, while the holistic hospice approach is better suited to the current per diem reimbursement.

Response: We appreciate the comment, but it is outside the scope of this final rule. We will, however, consider the comment when examining

visit reporting requirements in the future.

Comment: A commenter stated that phasing out the BNAF amounted to ''taxation without representation''.

Response: We followed the requirements of the Administrative Procedures Act in proposing and finalizing this policy change, including providing rationale for the BNAF phase-out and the opportunity for public comment (73 FR 24006).

Comment: A commenter did not want CMS to cut hospice payments. The commenter stated that Medicare was to help those without other sources of income.

Response: We thank the commenter for his or her input. Medicare is a health insurance benefit available to people 65 and older, some disabled people under age 65, and people of all ages with End Stage Renal Disease. While Medicare is certainly a help to those without much income, eligibility for Medicare is not related to income. Those who are Medicare beneficiaries fall into all income categories, from the lowest to the highest.

Comment: A commenter stated that non-hospice care is given at end-of-life, and asked that CMS change physician practice and enhance public awareness rather than reducing hospice payments. The commenter suggested that we allow only the attending physician to order non-emergency tests and treatments in hospitals; that we increase physician oversight of hospice patients; that we publicize actual success rates for various technologies; and that we restructure the physician payment system so that doctors are paid by diagnosis rather than by days in hospital or by procedures done.

Another commenter stated that CMS should evaluate the skilled benefits, as people that are hospice-appropriate are being sent to skilled facilities first, even though they are not rehab potentials.

One commenter stated that the federal government recognizes and uses a wage index in determining the salaries of their employees.

A different commenter recommended that CMS seek to limit the growth in the hospice benefit by requiring survey agencies to establish or enhance needs methodologies.

Several comments recommended other methods of saving federal dollars rather than phasing out the BNAF. One commenter stated that CMS should cut extreme farm subsidies. Another commenter stated that CMS should cut programs that reward illegal status in the U.S. A third commenter stated that CMS should stop those who are using Medicare dollars to buy expensive vehicles.

A commenter also stated that since Medicaid payments for hospice services are based on the Medicare payment methodology and rates, the BNAF phase-out will have an even greater effect on, and impinge on the provision of hospice services to Medicaid recipients.

Response: We appreciate these comments, but they are outside the scope of this final rule. References to literature cited in this section: Medicare Payment Advisory Commission (MedPAC), Report to Congress: Reforming the Delivery System, June 2008: 203–237.

III. Provisions of the Final Regulations

This final rule incorporates the provisions of the proposed rule. None of the provisions of this final rule differs from the proposed rule.

IV. Collection of Information Requirements

This document does not impose any information collection and recordkeeping requirements. Consequently, it does not need to be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

V. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)). We estimated the impact on hospices, as a result of the changes to the proposed FY 2009 hospice wage index and of reducing the BNAF by 25 percent. As discussed previously, the methodology for computing the hospice wage index was determined through a negotiated rulemaking committee and implemented in the August 8, 1997 final rule (62 FR 42860). This rule updates to the hospice wage index in accordance with our regulation but proposes to revise the Negotiated Rulemaking Committee methodology of including a BNAF.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits including potential economic, environmental, public health and safety effects, distributive impacts, and equity. A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We have determined that this final rule is an economically significant rule under this Executive Order.

Column 4 of Table 2 shows the combined effects of the 25 percent reduction in the BNAF and of the updated wage data, comparing estimated payments for FY 2009 to estimated payments for FY 2008. We estimate that the total hospice payments for FY 2009 will decrease by $100 million as a result of the application of the 25 percent reduction in the BNAF and the updated wage data. This estimate does not take into account the FY 2009 market basket update, which is 3.6 percent, and which will be communicated through an administrative instruction. The estimated impact of a 3.6 percent FY 2009 market basket update on payments to hospices is approximately $330 million. If we were to take into account the 3.6 percent FY 2009 market basket update, in addition to the 25 percent reduction in the BNAF and the updated wage data, it is estimated that hospice payments would increase by approximately $230 million ($330 million − $100 million = $230 million). The percent change in payments to hospices due to the combined effects of the 25 percent reduction in the BNAF, the updated wage data, and the FY 2009 market basket update of 3.6 percent is reflected in column 5 of the impact table (Table 2).

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. The great majority of hospices and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than $6.5 million to $31.5 million in any 1 year (for details, see the Small Business Administration's regulation at 65 FR 69432, that sets forth size standards for health care industries). As indicated in Table 2 below, there are 3,111 hospices. Approximately 50.9 percent of Medicare certified hospices are identified as voluntary, government, or other agencies and, therefore, are considered small entities. Most of these and most of the remainder are also small hospice entities because their revenues fall

below the SBA size thresholds. We note that the hospice wage index methodology was previously guided by consensus, through a negotiated rulemaking committee that included representatives of national hospice associations, rural, urban, large and small hospices, multi-site hospices, and consumer groups. Based on all of the options considered, the Committee agreed on the methodology described in the Committee Statement, and after notice and comment, it was adopted into regulation in the August 8, 1997 final rule. In developing the process for updating the hospice wage index in the 1997 final rule, we considered the impact of this methodology on small hospice entities and attempted to mitigate any potential negative effects. Small hospice entities are more likely to be in rural areas, which are less affected by the BNAF reduction than entities in urban areas. Generally, hospices in rural areas are protected by the hospice floor, which mitigates the effect of the BNAF reduction. The effects of this rule on hospices, as illustrated in Table 2, are small. Overall, Medicare payments to all hospices will decrease by an estimated 1.1 percent, reflecting the combined effects of the 25 percent reduction in the BNAF and the updated wage data. Within the hospice subgroups, Medicare payments will decrease by no more than 1.6 percent. Furthermore, when including the FY 2009 market basket update of 3.6 percent into these figures, the combined effects of Medicare payment changes to all hospices will result in an increase of approximately 2.5 percent. Overall average hospice revenue effects will be slightly less than these estimates since according to the National Hospice and Palliative Care Organization, about 16 percent of hospice caseload is non-Medicare. Longstanding HHS practice in interpreting the RFA is to consider effects economically ''significant'' only if they reach a threshold of 3 to 5 percent or more. Accordingly, we have determined that this final rule does not create a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a CBSA and has fewer than 100 beds. We have determined that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of about $130 million or more (the threshold in the statute, updated for inflation through 2008). This final rule will not have an effect on State, local, or tribal governments or on the private sector of $130 million or more.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this final rule under the threshold criteria of Executive Order 13132, Federalism, and have determined that it will not have an impact on the rights, roles, and responsibilities of State, local, or tribal governments.

B. Anticipated Effects

This section discusses the impact of the final rule, including the estimated effects of the 3.6 percent FY 2009 market basket update that will be communicated separately through an administrative instruction. The final rule includes continuing to use the CBSA-based raw pre-floor, pre-reclassified hospital wage index (to include the clarification of New England ''deemed'' counties and a change in the way that multi-campus hospital wage data are treated in the creation of the raw pre-floor, pre-reclassified hospital wage index), continuing the use the same policies for treatment of areas (rural and urban) without hospital wage data, and reducing the BNAF by 25 percent for the first year of a 3-year BNAF phase-out. The final FY 2009 hospice wage index is based upon the 2008 raw pre-floor, pre-reclassified hospital wage index and the most complete claims data available (FY 2007 as of March 2008) with a 25 percent reduction in the BNAF.

For the purposes of our impacts, our baseline is estimated FY 2008 payments using the 2007 raw pre-floor, pre-reclassified hospital wage index. Our first comparison (column 3, Table 2) compares our baseline to estimated FY 2009 payments (holding payment rates constant) using the updated wage data (2008 raw pre-floor, pre-reclassified hospital wage index). Consequently, the estimated effects illustrated in column 3 of Table 2 are for the updated wage data only. The effects of using the updated raw pre-floor, pre-reclassified hospital wage index data combined with the 25 percent reduction in the BNAF are illustrated in column 4 of Table 2.

Even though the market basket update is not part of this final rule, we have included a comparison of the combined effects of the 25 percent BNAF reduction, the updated raw pre-floor, pre-reclassified hospital wage index, and the 3.6 percent FY 2009 market basket increase for FY 2009 (Table 2, column 5). Presenting these data gives the hospice industry a more complete picture of the effects of the proposed changes in this rule and of the market basket update. Certain events may limit the scope or accuracy of our impact analysis, because such an analysis is susceptible to forecasting errors due to other changes in the forecasted impact time period. The nature of the Medicare program is that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon hospices.

TABLE 2—ANTICIPATED IMPACT ON MEDICARE HOSPICE PAYMENTS OF REDUCING THE BNAF, UPDATING THE RAW PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX DATA, AND APPLYING A 3.6 PERCENT MARKET BASKET UPDATE FOR THE FINAL FY 2009 HOSPICE WAGE INDEX, COMPARED TO THE PUBLISHED FINAL FY 2008 HOSPICE WAGE INDEX

	Number of hospices* (1)	Number of routine home care days in thousands (2)	Percent change in hospice payments due to FY 2009 wage index change (3)	Percent change in hospice payments due to wage index change and 25% reduction in budget neutrality adjustment factor (4)	Percent change in hospice payments due to wage index change, 25% reduction in budget neutrality adjustment factor and market basket update (5)
ALL HOSPICES	3,111	67,239	0.0	−1.1	2.5
URBAN HOSPICES	2,098	57,893	0.0	−1.1	2.5
RURAL HOSPICES	1,013	9,346	−0.1	−0.9	2.7
BY REGION—URBAN**:					
NEW ENGLAND	119	2,074	0.4	−0.7	2.9
MIDDLE ATLANTIC	209	5,971	−0.5	−1.5	2.0
SOUTH ATLANTIC	310	12,950	0.0	−1.1	2.5
EAST NORTH CENTRAL	307	8,324	−0.2	−1.3	2.3
EAST SOUTH CENTRAL	170	4,506	−0.4	−1.3	2.3
WEST NORTH CENTRAL	166	3,783	0.1	−1.0	2.6
WEST SOUTH CENTRAL	348	7,588	−0.1	−1.2	2.4
MOUNTAIN	201	5,054	0.0	−1.1	2.5
PACIFIC	234	6,692	0.8	−0.3	3.3
OUTLYING	34	952	−1.1	−1.1	2.4
BY REGION—RURAL**:					
NEW ENGLAND	26	175	−0.4	−1.4	2.1
MIDDLE ATLANTIC	44	462	0.4	−0.6	2.9
SOUTH ATLANTIC	128	1,915	0.1	−0.9	2.7
EAST NORTH CENTRAL	144	1,317	0.0	−1.0	2.5
EAST SOUTH CENTRAL	152	2,051	−0.4	−1.1	2.4
WEST NORTH CENTRAL	192	1,030	−0.2	−1.2	2.3
WEST SOUTH CENTRAL	168	1,388	−0.5	−0.8	2.8
MOUNTAIN	106	601	0.2	−0.8	2.8
PACIFIC	52	397	1.6	0.5	4.1
OUTLYING	1	9	0.0	0.0	3.6
ROUTINE HOME CARE DAYS:					
0–3,499 DAYS (small)	607	1,044	0.1	−0.8	2.7
3,500–19,999 DAYS (medium)	1,506	15,071	−0.1	−1.1	2.5
20,000+ DAYS (large)	998	51,123	0.0	−1.1	2.5
TYPE OF OWNERSHIP:					
VOLUNTARY	1,198	29,597	−0.1	−1.2	2.4
PROPRIETARY	1,528	32,903	0.0	−1.0	2.6
GOVERNMENT	192	1,049	0.2	−0.8	2.8
OTHER†	193	3,690	0.1	−1.0	2.6
HOSPICE BASE:					
FREESTANDING	1,918	49,843	0.0	−1.1	2.5
HOME HEALTH AGENCY	609	9,816	0.1	−1.0	2.6
HOSPITAL	567	7,329	0.1	−1.0	2.6
SKILLED NURSING FACILITY	17	251	−0.5	−1.6	2.0

*As of February, 2008; for this final rule, used FY 2007 claims as of March 2008.

**New England = Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; Middle Atlantic = Pennsylvania, New Jersey, New York; South Atlantic = Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia; East North Central = Illinois, Indiana, Michigan, Ohio, Wisconsin; East South Central = Alabama, Kentucky, Mississippi, Tennessee; West North Central = Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota; West South Central = Arkansas, Louisiana, Oklahoma, Texas; Mountain = Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming; Pacific = Alaska, California, Hawaii, Oregon, Washington; Outlying = Guam, Puerto Rico, Virgin Islands.

†This category refers to other government hospices.

Table 2 shows the results of our analysis. In column 1 we indicate the number of hospices included in our analysis as of February 2008 which had claims in FY 2007. In column 2, we indicate the number of routine home care days that were included in our analysis, although the analysis was performed on all types of hospice care. Column 3 shows the percentage change in estimated Medicare payments from FY 2008 to FY 2009 due to the effects of the updated wage data only. Column 4 shows the percentage change in estimated hospice payments from FY 2008 to FY 2009 due to the combined effects of using the 2008 raw pre-floor, pre-reclassified hospital wage index and

reducing the BNAF by 25 percent. Column 5 shows the percentage change in estimated hospice payments from FY 2008 to FY 2009 due to the combined effects of using updated wage data, a 25 percent BNAF reduction, and the 3.6 percent FY 2009 market basket update.

Table 2 also categorizes hospices by various geographic and provider characteristics. The first row of data displays the aggregate result of the impact for all Medicare-certified hospices. The second and third rows of the table categorize hospices according to their geographic location (urban and rural). Our analysis indicated that there are 2,098 hospices located in urban areas and 1,013 hospices located in rural areas. The next two row groupings in the table indicate the number of hospices by census region, also broken down by urban and rural hospices. The next grouping shows the impact on hospices based on the size of the hospice's program. We determined that the majority of hospice payments are made at the routine home care rate. Therefore, we based the size of each individual hospice's program on the number of routine home care days provided in FY 2007. The next grouping shows the impact on hospices by type of ownership. The final grouping shows the impact on hospices defined by whether they are provider-based or freestanding.

As indicated in Table 2, there are 3,111 hospices. Approximately 50.9 percent of Medicare-certified hospices are identified as voluntary, government, or other government agencies and, therefore, are considered small entities. Because the National Hospice and Palliative Care Organization estimates that approximately 83.7 percent of hospice patients are Medicare beneficiaries, we have not considered other sources of revenue in this analysis. As noted earlier, those CBSAs which had the hospice floor applied prior to our proposal to reduce the BNAF are unaffected by this proposed change in methodology. Those CBSAs that were not previously less than 0.8 after applying the full BNAF but which are now less than 0.8 after applying the reduced BNAF will see less of a reduction in payments as the floor protects their hospice wage index value.

As stated previously, the following discussions are limited to demonstrating trends rather than projected dollars. We used the raw pre-floor, pre-reclassified hospital wage indexes as well as the most complete claims data available (FY 2007 as of March 2008) in developing the impact analysis. The FY 2009 payment rates were adjusted to reflect the full market basket, as required by section 1814(i)(1)(C)(ii)(VII) of the Act. As previously noted, we publish these rates through administrative instructions rather than in a proposed rule. The FY 2008 update was 3.3 percent, and the FY 2009 update is 3.6 percent. Since the inclusion of the effect of a market basket increase provides a more complete picture of estimated hospice payments for FY 2009, the last column of Table 2 shows the combined impacts of the 25 percent BNAF reduction, the updated wage index, and a 3.6 percent market basket update factor.

As discussed in the FY 2006 final rule (70 FR 45129), hospice agencies may use multiple hospice wage index values to compute their payments based on potentially different geographic locations. Before January 1, 2008, the location of the beneficiary was used to determine the CBSA for routine and continuous home care and the location of the hospice agency was used to determine the CBSA for respite and general inpatient care. Beginning January 1, 2008, the hospice wage index utilized is based on the location of the site of service. As the location of the beneficiary's home and the location of the facility may vary, there will still be variability in geographic location for an individual hospice. We anticipate that the location of the various sites will usually correspond with the geographic location of the hospice, and thus we will continue to use the location of the hospice for our analyses of the impact of the proposed changes to the hospice wage index in this rule. For this analysis, we use payments to the hospice in the aggregate based on the location of the hospice.

The impact of hospice wage index changes has been analyzed according to the type of hospice, geographic location, type of ownership, hospice base, and size. Our analysis shows that most hospices are in urban areas and provide the vast majority of routine home care days. Most hospices are medium-sized followed by large hospices. Hospices are almost equal in numbers by ownership with 1,583 designated as non-profit and 1,528 as proprietary. The vast majority of hospices are freestanding.

1. Hospice Size

Under the Medicare hospice benefit, hospices can provide four different levels of care days. The majority of the days provided by a hospice are routine home care (RHC) days representing about 97 percent of the services provided by a hospice. Therefore, the number of RHC days can be used as a proxy for the size of the hospice, that is, the more days of care provided, the larger the hospice. As discussed in the August 4, 2005 final rule, we currently use three size designations to present the impact analyses. The three categories are: (1) Small agencies having 0 to 3,499 RHC days; (2) medium agencies having 3,500 to 19,999 RHC days; and (3) large agencies having 20,000 or more RHC days. The final FY 2009 wage index values without the BNAF reduction are anticipated to have a 0.1 percent increase on small hospice providers, a 0.1 percent decrease anticipated for medium hospices, and no change anticipated for large hospices (column 3); the final FY 2009 wage index values with the 25 percent BNAF reduction and the updated wage data are anticipated to decrease estimated payments by 0.8 percent to small hospices and by 1.1 percent to medium and large hospices (column 4); and finally, the final FY 2009 wage index values with the 25 percent BNAF reduction, the updated wage data, and the 3.6 percent FY 2009 market basket update are projected to increase estimated payments by 2.7 percent for small hospices and by 2.5 percent for medium and large hospices (column 5).

2. Geographic Location

Column 3 of Table 2 shows that FY 2009 wage index values without the BNAF reduction will result in little change in estimated payments with no anticipated change for urban hospices and an anticipated decrease of 0.1 percent for rural hospices. For urban hospices, the greatest increase of 0.8 percent is anticipated to be experienced by the Pacific regions, followed by an increase for New England of 0.4 percent, an increase of 0.1 percent for West North Central, and no change for the South Atlantic and Mountain regions. The remaining urban regions are anticipated to experience a decrease ranging from 0.1 percent in the West South Central region to 1.1 percent in Puerto Rico.

Column 3 shows that for rural hospices, Puerto Rico and the East North Central regions are anticipated to experience no change. Four regions are anticipated to experience a decrease ranging from 0.2 percent for the West North Central region to 0.5 percent for West South Central region. The remaining regions are anticipated to experience an increase ranging from 0.1 percent for the South Atlantic region to 1.6 percent for the Pacific region.

Column 4 shows the combined effect of the 25 percent BNAF reduction and the updated raw pre-floor, pre-reclassified hospital wage index values on estimated payments, as compared to the published FY 2008 payments.

Overall urban hospices are anticipated to experience a 1.1 percent decrease in payments, while rural hospices can expect a 0.9 percent decrease. The estimated percent decrease in payment for urban hospices ranged from 0.3 percent for Pacific hospices to 1.5 percent for Middle Atlantic hospices.

The estimated percent decrease in payment for rural hospices ranged from 0.6 percent for Middle Atlantic hospices to 1.4 percent for New England hospices. Rural Puerto Rico's estimated payments were unaffected, and the Pacific region saw a 0.5 percent increase in estimated payments.

Column 5 shows the combined effects of the final FY 2009 wage index values with the 25 percent BNAF reduction, the updated wage data, and the 3.6 percent FY 2009 market basket update on estimated payments as compared to the published FY 2008 payments. Overall, urban hospices are anticipated to experience a 2.5 percent increase in payments while rural hospices should experience a 2.7 percent increase in payments. Urban hospices are anticipated to see an increase in estimated payments ranging from 2.0 percent for the Middle Atlantic region to 3.3 percent for the Pacific region. Rural hospices are estimated to see an increase in estimated payments ranging from 2.1 percent for the New England region to 4.1 percent for the Pacific region.

3. Type of Ownership

Column 3 demonstrates the effect of the updated raw pre-floor, pre-reclassified hospital wage index on FY 2009 estimated payments versus FY 2008 estimated payments. We anticipate that using the updated raw pre-floor, pre-reclassified hospital wage index data will have no effect on proprietary hospices. While we estimate a slight decrease in estimated payments for voluntary (non-profit) hospices (0.1 percent), other hospices are expected to experience an increase of 0.1 percent, and government hospices are expected to experience an increase of 0.2 percent.

Column 4 demonstrates the combined effects of using updated raw pre-floor, pre-reclassified hospital wage index data and of incorporating a 25 percent BNAF reduction. Estimated payments to proprietary hospices are anticipated to decrease by 1.0 percent, while voluntary (non-profit), government, and other hospices are anticipated to experience decreases of 1.2 percent, 0.8 percent, and 1.0 percent, respectively.

Column 5 shows the combined effects of the updated raw pre-floor, pre-reclassified hospital wage index values with the 25 percent BNAF reduction, the updated wage data, and the 3.6 percent FY 2009 market basket update on estimated payments, comparing FY 2009 to FY 2008. Estimated FY 2009 payments are anticipated to increase for all hospices, regardless of ownership type. Estimated payments are forecast to increase from 2.4 percent for voluntary hospices to 2.8 percent for government hospices.

4. Hospice Base

Column 3 demonstrates the effect of using the updated raw pre-floor, pre-reclassified hospital wage index values, comparing estimated payments for FY 2009 to FY 2008. Estimated payments are anticipated to decrease by 0.5 percent for skilled nursing facilities, but to increase for home health agency and hospital based facilities. Freestanding facilities are anticipated to experience no change in estimated payments.

Column 4 shows the combined effects of reducing the BNAF by 25 percent and updating the raw pre-floor, pre-reclassified hospital wage index values, comparing FY 2009 to FY 2008 estimated payments. Skilled nursing facility based hospices are estimated to see a 1.6 percent decline, while hospital based hospices and home health agency based hospices are each anticipated to experience a 1.0 percent decrease in payments. Freestanding hospices are expected to experience a 1.1 percent decrease.

Column 5 shows the combined effects of the 25 percent BNAF reduction, the updated raw pre-floor, pre-reclassified hospital wage index, and the 3.6 percent FY 2009 market basket update on estimated payments, comparing FY 2009 to FY 2008. Estimated increases in payments range from 2.0 percent for skilled nursing facility based hospices to 2.6 percent for home health agency based hospices and hospital based hospices.

We note that the President's budget includes a proposal for a zero percent payment update for hospices in FY 2009. The impacts outlined in Column 5 of Table 2 in this final rule, which include the effects of a 3.6 percent FY 2009 market basket update, would need to change to reflect any legislation that the Congress might enact which would affect the market basket update.

C. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 3 below, we have prepared an accounting statement showing the classification of the expenditures associated with the final provisions of this rule. This table provides our best estimate of the decrease in Medicare payments under the hospice benefit as a result of the changes presented in this final rule on data for 3,111 hospices in our database. All expenditures are classified as transfers to Medicare providers (that is, hospices).

TABLE 3—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM FY 2008 TO FY 2009

[In millions]

Category	Transfers
Annualized Monetized Transfers.	$ −100 *
From Whom to Whom	Federal Government to Hospices

*The $100 million reduction in transfers includes the 25 percent reduction in the BNAF and the updated wage data. It does not include the market basket update of 3.6 percent.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 418

Health facilities, Health professions, Medicare, and Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare and Medicare Services amends 42 CFR chapter IV as set forth below:

PART 418—HOSPICE CARE

■ 1. The authority citation for part 418 continues to read as follows:

Authority: Secs 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart G—Payment for Hospice Care

■ 2. Section § 418.306 is amended by revising paragraph (c) to read as follows:

§ 418.306 Determination of payment rates.

* * * * *

(c) *Adjustment for wage differences.* Each hospice's labor market is determined based on definitions of Metropolitan Statistical Areas (MSAs) issued by OMB. CMS will issue annually, in the **Federal Register**, a hospice wage index based on the most current available CMS hospital wage data, including changes to the definition of MSAs. The urban and rural area geographic classifications are defined in § 412.64(b)(1)(ii)(A) through (C) of this chapter. The payment rates established by CMS are adjusted by the intermediary to reflect local differences

in wages according to the revised wage data.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: July 18, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: July 24, 2008.

Michael O. Leavitt,

Secretary.

Note: The following Addenda will not appear in the Code of Federal Regulations.

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
10180	Abilene, TX	0.8352
	Callahan County, TX	
	Jones County, TX	
	Taylor County, TX	
10380	Aguadilla-Isabela-San Sebastián, PR	0.3965
	Aguada Municipio, PR	
	Aguadilla Municipio, PR	
	Añasco Municipio, PR	
	Isabela Municipio, PR	
	Lares Municipio, PR	
	Moca Municipio, PR	
	Rincón Municipio, PR	
	San Sebastián Municipio, PR	
10420	Akron, OH	0.9231
	Portage County, OH	
	Summit County, OH	
10500	Albany, GA	0.8937
	Baker County, GA	
	Dougherty County, GA	
	Lee County, GA	
	Terrell County, GA	
	Worth County, GA	
10580	Albany-Schenectady-Troy, NY	0.9015
	Albany County, NY	
	Rensselaer County, NY	
	Saratoga County, NY	
	Schenectady County, NY	
	Schoharie County, NY	
10740	Albuquerque, NM	1.0029
	Bernalillo County, NM	
	Sandoval County, NM	
	Torrance County, NM	
	Valencia County, NM	
10780	Alexandria, LA	0.8375
	Grant Parish, LA	
	Rapides Parish, LA	
10900	Allentown-Bethlehem-Easton, PA-NJ	1.0355
	Warren County, NJ	
	Carbon County, PA	
	Lehigh County, PA	
	Northampton County, PA	
11020	Altoona, PA	0.9046
	Blair County, PA	
11100	Amarillo, TX	0.9569
	Armstrong County, TX	
	Carson County, TX	
	Potter County, TX	
	Randall County, TX	
11180	Ames, IA	1.0545
	Story County, IA	
11260	Anchorage, AK	1.2505
	Anchorage Municipality, AK	
	Matanuska-Susitna Borough, AK	
11300	Anderson, IN	0.9266
	Madison County, IN	
11340	Anderson, SC	0.9537
	Anderson County, SC	
11460	Ann Arbor, MI	1.1063
	Washtenaw County, MI	
11500	Anniston-Oxford, AL	0.8320

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
	Calhoun County, AL	
11540	Appleton, WI	1.0075
	Calumet County, WI	
	Outagamie County, WI	
11700	Asheville, NC	0.9641
	Buncombe County, NC	
	Haywood County, NC	
	Henderson County, NC	
	Madison County, NC	
12020	Athens-Clarke County, GA	1.1040
	Clarke County, GA	
	Madison County, GA	
	Oconee County, GA	
	Oglethorpe County, GA	
12060	Atlanta-Sandy Springs-Marietta, GA	1.0316
	Barrow County, GA	
	Bartow County, GA	
	Butts County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	Cobb County, GA	
	Coweta County, GA	
	Dawson County, GA	
	DeKalb County, GA	
	Douglas County, GA	
	Fayette County, GA	
	Forsyth County, GA	
	Fulton County, GA	
	Gwinnett County, GA	
	Haralson County, GA	
	Heard County, GA	
	Henry County, GA	
	Jasper County, GA	
	Lamar County, GA	
	Meriwether County, GA	
	Newton County, GA	
	Paulding County, GA	
	Pickens County, GA	
	Pike County, GA	
	Rockdale County, GA	
	Spalding County, GA	
	Walton County, GA	
12100	Atlantic City, NJ	1.2804
	Atlantic County, NJ	
12220	Auburn-Opelika, AL	0.8492
	Lee County, AL	
12260	Augusta-Richmond County, GA-SC	1.0124
	Burke County, GA	
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
	Edgefield County, SC	
12420	Austin-Round Rock, TX	1.0018
	Bastrop County, TX	
	Caldwell County, TX	
	Hays County, TX	
	Travis County, TX	
	Williamson County, TX	
12540	Bakersfield, CA	1.1600
	Kern County, CA	
12580	Baltimore-Towson, MD	1.0638
	Anne Arundel County, MD	
	Baltimore County, MD	
	Carroll County, MD	
	Harford County, MD	
	Howard County, MD	
	Queen Anne's County, MD	
	Baltimore City, MD	
12620	Bangor, ME	1.0474

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
	Penobscot County, ME	
12700	Barnstable Town, MA	1.3229
	Barnstable County, MA	
12940	Baton Rouge, LA	0.8433
	Ascension Parish, LA	
	East Baton Rouge Parish, LA	
	East Feliciana Parish, LA	
	Iberville Parish, LA	
	Livingston Parish, LA	
	Pointe Coupee Parish, LA	
	St. Helena Parish, LA	
	West Baton Rouge Parish, LA	
	West Feliciana Parish, LA	
12980	Battle Creek, MI	1.0685
	Calhoun County, MI	
13020	Bay City, MI	0.9339
	Bay County, MI	
13140	Beaumont-Port Arthur, TX	0.8955
	Hardin County, TX	
	Jefferson County, TX	
	Orange County, TX	
13380	Bellingham, WA	1.2044
	Whatcom County, WA	
13460	Bend, OR	1.1486
	Deschutes County, OR	
13644	Bethesda-Frederick-Gaithersburg, MD	1.1033
	Frederick County, MD	
	Montgomery County, MD	
13740	Billings, MT	0.9097
	Carbon County, MT	
	Yellowstone County, MT	
13780	Binghamton, NY	0.9394
	Broome County, NY	
	Tioga County, NY	
13820	Birmingham-Hoover, AL	0.9340
	Bibb County, AL	
	Blount County, AL	
	Chilton County, AL	
	Jefferson County, AL	
	St. Clair County, AL	
	Shelby County, AL	
	Walker County, AL	
13900	Bismarck, ND	0.8000
	Burleigh County, ND	
	Morton County, ND	
13980	Blacksburg-Christiansburg-Radford, VA	0.8599
	Giles County, VA	
	Montgomery County, VA	
	Pulaski County, VA	
	Radford City, VA	
14020	Bloomington, IN	0.9358
	Greene County, IN	
	Monroe County, IN	
	Owen County, IN	
14060	Bloomington-Normal, IL	0.9788
	McLean County, IL	
14260	Boise City-Nampa, ID	0.9935
	Ada County, ID	
	Boise County, ID	
	Canyon County, ID	
	Gem County, ID	
	Owyhee County, ID	
14484	Boston-Quincy, MA	1.2378
	Norfolk County, MA	
	Plymouth County, MA	
	Suffolk County, MA	
14500	Boulder, CO	1.0944
	Boulder County, CO	
14540	Bowling Green, KY	0.8564
	Edmonson County, KY	
	Warren County, KY	

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
14740	Bremerton-Silverdale, WA	1.1446
	Kitsap County, WA	
14860	Bridgeport-Stamford-Norwalk, CT	1.3368
	Fairfield County, CT	
15180	Brownsville-Harlingen, TX	0.9357
	Cameron County, TX	
15260	Brunswick, GA	0.9946
	Brantley County, GA	
	Glynn County, GA	
	McIntosh County, GA	
15380	Buffalo-Niagara Falls, NY	1.0043
	Erie County, NY	
	Niagara County, NY	
15500	Burlington, NC	0.9182
	Alamance County, NC	
15540	Burlington-South Burlington, VT	1.0140
	Chittenden County, VT	
	Franklin County, VT	
	Grand Isle County, VT	
15764	Cambridge-Newton-Framingham, MA	1.1772
	Middlesex County, MA	
15804	Camden, NJ	1.0928
	Burlington County, NJ	
	Camden County, NJ	
	Gloucester County, NJ	
15940	Canton-Massillon, OH	0.9379
	Carroll County, OH	
	Stark County, OH	
15980	Cape Coral-Fort Myers, FL	0.9863
	Lee County, FL	
16180	Carson City, NV	1.0500
16220	Casper, WY	0.9851
	Natrona County, WY	
16300	Cedar Rapids, IA	0.9292
	Benton County, IA	
	Jones County, IA	
	Linn County, IA	
16580	Champaign-Urbana, IL	0.9859
	Champaign County, IL	
	Ford County, IL	
	Piatt County, IL	
16620	Charleston, WV	0.8701
	Boone County, WV	
	Clay County, WV	
	Kanawha County, WV	
	Lincoln County, WV	
	Putnam County, WV	
16700	Charleston-North Charleston, SC	0.9577
	Berkeley County, SC	
	Charleston County, SC	
	Dorchester County, SC	
16740	Charlotte-Gastonia-Concord, NC-SC	0.9993
	Anson County, NC	
	Cabarrus County, NC	
	Gaston County, NC	
	Mecklenburg County, NC	
	Union County, NC	
	York County, SC	
16820	Charlottesville, VA	0.9738
	Albemarle County, VA	
	Fluvanna County, VA	
	Greene County, VA	
	Nelson County, VA	
	Charlottesville City, VA	
16860	Chattanooga, TN-GA	0.9441
	Catoosa County, GA	
	Dade County, GA	
	Walker County, GA	
	Hamilton County, TN	
	Marion County, TN	
	Sequatchie County, TN	

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
16940	Cheyenne, WY	0.9771
	Laramie County, WY	
16974	Chicago-Naperville-Joliet, IL	1.1247
	Cook County, IL	
	DeKalb County, IL	
	DuPage County, IL	
	Grundy County, IL	
	Kane County, IL	
	Kendall County, IL	
	McHenry County, IL	
	Will County, IL	
17020	Chico, CA	1.1851
	Butte County, CA	
17140	Cincinnati-Middletown, OH-KY-IN	1.0270
	Dearborn County, IN	
	Franklin County, IN	
	Ohio County, IN	
	Boone County, KY	
	Bracken County, KY	
	Campbell County, KY	
	Gallatin County, KY	
	Grant County, KY	
	Kenton County, KY	
	Pendleton County, KY	
	Brown County, OH	
	Butler County, OH	
	Clermont County, OH	
	Hamilton County, OH	
	Warren County, OH	
17300	Clarksville, TN-KY	0.8661
	Christian County, KY	
	Trigg County, KY	
	Montgomery County, TN	
	Stewart County, TN	
17420	Cleveland, TN	0.8452
	Bradley County, TN	
	Polk County, TN	
17460	Cleveland-Elyria-Mentor, OH	0.9803
	Cuyahoga County, OH	
	Geauga County, OH	
	Lake County, OH	
	Lorain County, OH	
	Medina County, OH	
17660	Coeur d'Alene, ID	1.0006
	Kootenai County, ID	
17780	College Station-Bryan, TX	0.9823
	Brazos County, TX	
	Burleson County, TX	
	Robertson County, TX	
17820	Colorado Springs, CO	1.0202
	El Paso County, CO	
	Teller County, CO	
17860	Columbia, MO	0.9088
	Boone County, MO	
	Howard County, MO	
17900	Columbia, SC	0.9237
	Calhoun County, SC	
	Fairfield County, SC	
	Kershaw County, SC	
	Lexington County, SC	
	Richland County, SC	
	Saluda County, SC	
17980	Columbus, GA-AL	0.9163
	Russell County, AL	
	Chattahoochee County, GA	
	Harris County, GA	
	Marion County, GA	
	Muscogee County, GA	
18020	Columbus, IN	1.0011
	Bartholomew County, IN	
18140	Columbus, OH	1.0586

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
	Delaware County, OH	
	Fairfield County, OH	
	Franklin County, OH	
	Licking County, OH	
	Madison County, OH	
	Morrow County, OH	
	Pickaway County, OH	
	Union County, OH	
18580	Corpus Christi, TX	0.9015
	Aransas County, TX	
	Nueces County, TX	
	San Patricio County, TX	
18700	Corvallis, OR	1.1504
	Benton County, OR	
19060	Cumberland, MD-WV	0.8706
	Allegany County, MD	
	Mineral County, WV	
19124	Dallas-Plano-Irving, TX	1.0408
	Collin County, TX	
	Dallas County, TX	
	Delta County, TX	
	Denton County, TX	
	Ellis County, TX	
	Hunt County, TX	
	Kaufman County, TX	
	Rockwall County, TX	
19140	Dalton, GA	0.9195
	Murray County, GA	
	Whitfield County, GA	
19180	Danville, IL	0.9402
	Vermilion County, IL	
19260	Danville, VA	0.8649
	Pittsylvania County, VA	
	Danville City, VA	
19340	Davenport-Moline-Rock Island, IA-IL	0.9269
	Henry County, IL	
	Mercer County, IL	
	Rock Island County, IL	
	Scott County, IA	
19380	Dayton, OH	0.9647
	Greene County, OH	
	Miami County, OH	
	Montgomery County, OH	
	Preble County, OH	
19460	Decatur, AL	0.8277
	Lawrence County, AL	
	Morgan County, AL	
19500	Decatur, IL	0.8475
	Macon County, IL	
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.9480
	Volusia County, FL	
19740	Denver-Aurora, CO	1.1251
	Adams County, CO	
	Arapahoe County, CO	
	Broomfield County, CO	
	Clear Creek County, CO	
	Denver County, CO	
	Douglas County, CO	
	Elbert County, CO	
	Gilpin County, CO	
	Jefferson County, CO	
	Park County, CO	
19780	Des Moines-West Des Moines, IA	0.9684
	Dallas County, IA	
	Guthrie County, IA	
	Madison County, IA	
	Polk County, IA	
	Warren County, IA	
19804	Detroit-Livonia-Dearborn, MI	1.0496
	Wayne County, MI	
20020	Dothan, AL	0.8000

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
	Geneva County, AL	
	Henry County, AL	
	Houston County, AL	
20100	Dover, DE	1.0601
	Kent County, DE	
20220	Dubuque, IA	0.9508
	Dubuque County, IA	
20260	Duluth, MN-WI	1.0471
	Carlton County, MN	
	St. Louis County, MN	
	Douglas County, WI	
20500	Durham, NC	1.0304
	Chatham County, NC	
	Durham County, NC	
	Orange County, NC	
	Person County, NC	
20740	Eau Claire, WI	0.9946
	Chippewa County, WI	
	Eau Claire County, WI	
20764	Edison, NJ	1.1737
	Middlesex County, NJ	
	Monmouth County, NJ	
	Ocean County, NJ	
	Somerset County, NJ	
20940	El Centro, CA	0.9357
	Imperial County, CA	
21060	Elizabethtown, KY	0.9144
	Hardin County, KY	
	Larue County, KY	
21140	Elkhart-Goshen, IN	1.0089
	Elkhart County, IN	
21300	Elmira, NY	0.8675
	Chemung County, NY	
21340	El Paso, TX	0.9436
	El Paso County, TX	
21500	Erie, PA	0.8917
	Erie County, PA	
21660	Eugene-Springfield, OR	1.1475
	Lane County, OR	
21780	Evansville, IN-KY	0.9092
	Gibson County, IN	
	Posey County, IN	
	Vanderburgh County, IN	
	Warrick County, IN	
	Henderson County, KY	
	Webster County, KY	
21820	Fairbanks, AK	1.1599
	Fairbanks North Star Borough, AK	
21940	Fajardo, PR	0.5031
	Ceiba Municipio, PR	
	Fajardo Municipio, PR	
	Luquillo Municipio, PR	
22020	Fargo, ND-MN	0.8442
	Cass County, ND	
	Clay County, MN	
22140	Farmington, NM	1.0063
	San Juan County, NM	
22180	Fayetteville, NC	0.9834
	Cumberland County, NC	
	Hoke County, NC	
22220	Fayetteville-Springdale-Rogers, AR-MO	0.9176
	Benton County, AR	
	Madison County, AR	
	Washington County, AR	
	McDonald County, MO	
22380	Flagstaff, AZ	1.2268
	Coconino County, AZ	
22420	Flint, MI	1.1778
	Genesee County, MI	
22500	Florence, SC	0.8659
	Darlington County, SC	

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
	Florence County, SC	
22520	Florence-Muscle Shoals, AL	0.8062
	Colbert County, AL	
	Lauderdale County, AL	
22540	Fond du Lac, WI	1.0147
	Fond du Lac County, WI	
22660	Fort Collins-Loveland, CO	1.0389
	Larimer County, CO	
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0737
	Broward County, FL	
22900	Fort Smith, AR-OK	0.8327
	Crawford County, AR	
	Franklin County, AR	
	Sebastian County, AR	
	Le Flore County, OK	
	Sequoyah County, OK	
23020	Fort Walton Beach-Crestview-Destin, FL	0.9177
	Okaloosa County, FL	
23060	Fort Wayne, IN	0.9745
	Allen County, IN	
	Wells County, IN	
	Whitley County, IN	
23104	Fort Worth-Arlington, TX	1.0175
	Johnson County, TX	
	Parker County, TX	
	Tarrant County, TX	
	Wise County, TX	
23420	Fresno, CA	1.1539
	Fresno County, CA	
23460	Gadsden, AL	0.8564
	Etowah County, AL	
23540	Gainesville, FL	0.9653
	Alachua County, FL	
	Gilchrist County, FL	
23580	Gainesville, GA	0.9674
	Hall County, GA	
23844	Gary, IN	0.9682
	Jasper County, IN	
	Lake County, IN	
	Newton County, IN	
	Porter County, IN	
24020	Glens Falls, NY	0.8666
	Warren County, NY	
	Washington County, NY	
24140	Goldsboro, NC	0.9750
	Wayne County, NC	
24220	Grand Forks, ND-MN	0.8273
	Polk County, MN	
	Grand Forks County, ND	
24300	Grand Junction, CO	1.0354
	Mesa County, CO	
24340	Grand Rapids-Wyoming, MI	0.9778
	Barry County, MI	
	Ionia County, MI	
	Kent County, MI	
	Newaygo County, MI	
24500	Great Falls, MT	0.9106
	Cascade County, MT	
24540	Greeley, CO	1.0138
	Weld County, CO	
24580	Green Bay, WI	1.0210
	Brown County, WI	
	Kewaunee County, WI	
	Oconto County, WI	
24660	Greensboro-High Point, NC	0.9458
	Guilford County, NC	
	Randolph County, NC	
	Rockingham County, NC	
24780	Greenville, NC	0.9869
	Greene County, NC	
	Pitt County, NC	

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
24860	Greenville-Mauldin-Easley, SC	1.0350
	Greenville County, SC	
	Laurens County, SC	
	Pickens County, SC	
25020	Guayama, PR	0.3524
	Arroyo Municipio, PR	
	Guayama Municipio, PR	
	Patillas Municipio, PR	
25060	Gulfport-Biloxi, MS	0.9209
	Hancock County, MS	
	Harrison County, MS	
	Stone County, MS	
25180	Hagerstown-Martinsburg, MD–WV	0.9461
	Washington County, MD	
	Berkeley County, WV	
	Morgan County, WV	
25260	Hanford-Corcoran, CA	1.1021
	Kings County, CA	
25420	Harrisburg-Carlisle, PA	0.9741
	Cumberland County, PA	
	Dauphin County, PA	
	Perry County, PA	
25500	Harrisonburg, VA	0.9308
	Rockingham County, VA	
	Harrisonburg City, VA	
25540	Hartford-West Hartford-East Hartford, CT	1.1504
	Hartford County, CT	
	Middlesex County, CT	
	Tolland County, CT	
25620	Hattiesburg, MS	0.8000
	Forrest County, MS	
	Lamar County, MS	
	Perry County, MS	
25860	Hickory-Lenoir-Morganton, NC	0.9477
	Alexander County, NC	
	Burke County, NC	
	Caldwell County, NC	
	Catawba County, NC	
25980	Hinesville-Fort Stewart, GA [3]	0.9644
	Liberty County, GA	
	Long County, GA	
26100	Holland-Grand Haven, MI	0.9454
	Ottawa County, MI	
26180	Honolulu, HI	1.2130
	Honolulu County, HI	
26300	Hot Springs, AR	0.9562
	Garland County, AR	
26380	Houma-Bayou Cane-Thibodaux, LA	0.8284
	Lafourche Parish, LA	
	Terrebonne Parish, LA	
26420	Houston-Sugar Land-Baytown, TX	1.0433
	Austin County, TX	
	Brazoria County, TX	
	Chambers County, TX	
	Fort Bend County, TX	
	Galveston County, TX	
	Harris County, TX	
	Liberty County, TX	
	Montgomery County, TX	
	San Jacinto County, TX	
	Waller County, TX	
26580	Huntington-Ashland, WV-KY-OH	0.9490
	Boyd County, KY	
	Greenup County, KY	
	Lawrence County, OH	
	Cabell County, WV	
	Wayne County, WV	
26620	Huntsville, AL	0.9600
	Limestone County, AL	
	Madison County, AL	
26820	Idaho Falls, ID	0.9724

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
	Bonneville County, ID	
	Jefferson County, ID	
26900	Indianapolis-Carmel, IN	1.0333
	Boone County, IN	
	Brown County, IN	
	Hamilton County, IN	
	Hancock County, IN	
	Hendricks County, IN	
	Johnson County, IN	
	Marion County, IN	
	Morgan County, IN	
	Putnam County, IN	
	Shelby County, IN	
26980	Iowa City, IA	1.0043
	Johnson County, IA	
	Washington County, IA	
27060	Ithaca, NY	1.0109
	Tompkins County, NY	
27100	Jackson, MI	0.9793
	Jackson County, MI	
27140	Jackson, MS	0.8409
	Copiah County, MS	
	Hinds County, MS	
	Madison County, MS	
	Rankin County, MS	
	Simpson County, MS	
27180	Jackson, TN	0.9107
	Chester County, TN	
	Madison County, TN	
27260	Jacksonville, FL	0.9469
	Baker County, FL	
	Clay County, FL	
	Duval County, FL	
	Nassau County, FL	
	St. Johns County, FL	
27340	Jacksonville, NC	0.8480
	Onslow County, NC	
27500	Janesville, WI	1.0184
	Rock County, WI	
27620	Jefferson City, MO	0.8899
	Callaway County, MO	
	Cole County, MO	
	Moniteau County, MO	
	Osage County, MO	
27740	Johnson City, TN	0.8058
	Carter County, TN	
	Unicoi County, TN	
	Washington County, TN	
27780	Johnstown, PA	0.8000
	Cambria County, PA	
27860	Jonesboro, AR	0.8177
	Craighead County, AR	
	Poinsett County, AR	
27900	Joplin, MO	0.9396
	Jasper County, MO	
	Newton County, MO	
28020	Kalamazoo-Portage, MI	1.0951
	Kalamazoo County, MI	
	Van Buren County, MI	
28100	Kankakee-Bradley, IL	1.0747
	Kankakee County, IL	
28140	Kansas City, MO-KS	0.9976
	Franklin County, KS	
	Johnson County, KS	
	Leavenworth County, KS	
	Linn County, KS	
	Miami County, KS	
	Wyandotte County, KS	
	Bates County, MO	
	Caldwell County, MO	
	Cass County, MO	

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
	Clay County, MO	
	Clinton County, MO	
	Jackson County, MO	
	Lafayette County, MO	
	Platte County, MO	
	Ray County, MO	
28420	Kennewick-Richland-Pasco, WA	1.0576
	Benton County, WA	
	Franklin County, WA	
28660	Killeen-Temple-Fort Hood, TX	0.8659
	Bell County, TX	
	Coryell County, TX	
	Lampasas County, TX	
28700	Kingsport-Bristol-Bristol, TN-VA	0.8039
	Hawkins County, TN	
	Sullivan County, TN	
	Bristol City, VA	
	Scott County, VA	
	Washington County, VA	
28740	Kingston, NY	1.0031
	Ulster County, NY	
28940	Knoxville, TN	0.8435
	Anderson County, TN	
	Blount County, TN	
	Knox County, TN	
	Loudon County, TN	
	Union County, TN	
29020	Kokomo, IN	1.0068
	Howard County, IN	
	Tipton County, IN	
29100	La Crosse, WI-MN	1.0166
	Houston County, MN	
	La Crosse County, WI	
29140	Lafayette, IN	0.9310
	Benton County, IN	
	Carroll County, IN	
	Tippecanoe County, IN	
29180	Lafayette, LA	0.8657
	Lafayette Parish, LA	
	St. Martin Parish, LA	
29340	Lake Charles, LA	0.8163
	Calcasieu Parish, LA	
	Cameron Parish, LA	
29404	Lake County-Kenosha County, IL-WI	1.1130
	Lake County, IL	
	Kenosha County, WI	
29420	Lake Havasu City-Kingman, AZ	0.9797
	Mohave County, AZ	
29460	Lakeland, FL	0.9091
	Polk County, FL	
29540	Lancaster, PA	0.9712
	Lancaster County, PA	
29620	Lansing-East Lansing, MI	1.0622
	Clinton County, MI	
	Eaton County, MI	
	Ingham County, MI	
29700	Laredo, TX	0.8495
	Webb County, TX	
29740	Las Cruces, NM	0.9107
	Dona Ana County, NM	
29820	Las Vegas-Paradise, NV	1.2385
	Clark County, NV	
29940	Lawrence, KS	0.8636
	Douglas County, KS	
30020	Lawton, OK	0.8424
	Comanche County, OK	
30140	Lebanon, PA	0.8599
	Lebanon County, PA	
30300	Lewiston, ID-WA	0.9924
	Nez Perce County, ID	
	Asotin County, WA	

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
30340	Lewiston-Auburn, ME	0.9650
	Androscoggin County, ME	
30460	Lexington-Fayette, KY	0.9648
	Bourbon County, KY	
	Clark County, KY	
	Fayette County, KY	
	Jessamine County, KY	
	Scott County, KY	
	Woodford County, KY	
30620	Lima, OH	0.9892
	Allen County, OH	
30700	Lincoln, NE	1.0550
	Lancaster County, NE	
	Seward County, NE	
30780	Little Rock-North Little Rock-Conway, AR	0.9303
	Faulkner County, AR	
	Grant County, AR	
	Lonoke County, AR	
	Perry County, AR	
	Pulaski County, AR	
	Saline County, AR	
30860	Logan, UT-ID	0.9639
	Franklin County, ID	
	Cache County, UT	
30980	Longview, TX	0.9150
	Gregg County, TX	
	Rusk County, TX	
	Upshur County, TX	
31020	Longview, WA	1.1365
	Cowlitz County, WA	
31084	Los Angeles-Long Beach-Glendale, CA	1.2356
	Los Angeles County, CA	
31140	Louisville, KY-IN	0.9515
	Clark County, IN	
	Floyd County, IN	
	Harrison County, IN	
	Washington County, IN	
	Bullitt County, KY	
	Henry County, KY	
	Jefferson County, KY	
	Meade County, KY	
	Nelson County, KY	
	Oldham County, KY	
	Shelby County, KY	
	Spencer County, KY	
	Trimble County, KY	
31180	Lubbock, TX	0.9111
	Crosby County, TX	
	Lubbock County, TX	
31340	Lynchburg, VA	0.9166
	Amherst County, VA	
	Appomattox County, VA	
	Bedford County, VA	
	Campbell County, VA	
	Bedford City, VA	
	Lynchburg City, VA	
31420	Macon, GA	1.0015
	Bibb County, GA	
	Crawford County, GA	
	Jones County, GA	
	Monroe County, GA	
	Twiggs County, GA	
31460	Madera, CA	0.8470
	Madera County, CA	
31540	Madison, WI	1.1478
	Columbia County, WI	
	Dane County, WI	
	Iowa County, WI	
31700	Manchester-Nashua, NH	1.0783
	Hillsborough County, NH	
31900	Mansfield, OH	0.9732

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
	Richland County, OH	
32420	Mayagüez, PR	0.4268
	Hormigueros Municipio, PR	
	Mayagüez Municipio, PR	
32580	McAllen-Edinburg-Pharr, TX	0.9576
	Hidalgo County, TX	
32780	Medford, OR	1.0831
	Jackson County, OR	
32820	Memphis, TN-MS-AR	0.9710
	Crittenden County, AR	
	DeSoto County, MS	
	Marshall County, MS	
	Tate County, MS	
	Tunica County, MS	
	Fayette County, TN	
	Shelby County, TN	
	Tipton County, TN	
32900	Merced, CA	1.2722
	Merced County, CA	
33124	Miami-Miami Beach-Kendall, FL	1.0499
	Miami-Dade County, FL	
33140	Michigan City-La Porte, IN	0.9357
	LaPorte County, IN	
33260	Midland, TX	1.0515
	Midland County, TX	
33340	Milwaukee-Waukesha-West Allis, WI	1.0722
	Milwaukee County, WI	
	Ozaukee County, WI	
	Washington County, WI	
	Waukesha County, WI	
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.1644
	Anoka County, MN	
	Carver County, MN	
	Chisago County, MN	
	Dakota County, MN	
	Hennepin County, MN	
	Isanti County, MN	
	Ramsey County, MN	
	Scott County, MN	
	Sherburne County, MN	
	Washington County, MN	
	Wright County, MN	
	Pierce County, WI	
	St. Croix County, WI	
33540	Missoula, MT	0.9398
	Missoula County, MT	
33660	Mobile, AL	0.8432
	Mobile County, AL	
33700	Modesto, CA	1.2556
	Stanislaus County, CA	
33740	Monroe, LA	0.8221
	Ouachita Parish, LA	
	Union Parish, LA	
33780	Monroe, MI	0.9882
	Monroe County, MI	
33860	Montgomery, AL	0.8490
	Autauga County, AL	
	Elmore County, AL	
	Lowndes County, AL	
	Montgomery County, AL	
34060	Morgantown, WV	0.8734
	Monongalia County, WV	
	Preston County, WV	
34100	Morristown, TN	0.8000
	Grainger County, TN	
	Hamblen County, TN	
	Jefferson County, TN	
34580	Mount Vernon-Anacortes, WA	1.1052
	Skagit County, WA	
34620	Muncie, IN	0.8622
	Delaware County, IN	

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
34740	Muskegon-Norton Shores, MI	1.0325
	Muskegon County, MI	
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.9063
	Horry County, SC	
34900	Napa, CA	1.5195
	Napa County, CA	
34940	Naples-Marco Island, FL	0.9958
	Collier County, FL	
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	1.0170
	Cannon County, TN	
	Cheatham County, TN	
	Davidson County, TN	
	Dickson County, TN	
	Hickman County, TN	
	Macon County, TN	
	Robertson County, TN	
	Rutherford County, TN	
	Smith County, TN	
	Sumner County, TN	
	Trousdale County, TN	
	Williamson County, TN	
	Wilson County, TN	
35004	Nassau-Suffolk, NY	1.3268
	Nassau County, NY	
	Suffolk County, NY	
35084	Newark-Union, NJ-PA	1.2451
	Essex County, NJ	
	Hunterdon County, NJ	
	Morris County, NJ	
	Sussex County, NJ	
	Union County, NJ	
	Pike County, PA	
35300	New Haven-Milford, CT	1.2461
	New Haven County, CT	
35380	New Orleans-Metairie-Kenner, LA	0.9339
	Jefferson Parish, LA	
	Orleans Parish, LA	
	Plaquemines Parish, LA	
	St. Bernard Parish, LA	
	St. Charles Parish, LA	
	St. John the Baptist Parish, LA	
	St. Tammany Parish, LA	
35644	New York-Wayne-White Plains, NY-NJ	1.3767
	Bergen County, NJ	
	Hudson County, NJ	
	Passaic County, NJ	
	Bronx County, NY	
	Kings County, NY	
	New York County, NY	
	Putnam County, NY	
	Queens County, NY	
	Richmond County, NY	
	Rockland County, NY	
	Westchester County, NY	
35660	Niles-Benton Harbor, MI	0.9595
	Berrien County, MI	
35980	Norwich-New London, CT	1.2000
	New London County, CT	
36084	Oakland-Fremont-Hayward, CA	1.6464
	Alameda County, CA	
	Contra Costa County, CA	
36100	Ocala, FL	0.9056
	Marion County, FL	
36140	Ocean City, NJ	1.1534
	Cape May County, NJ	
36220	Odessa, TX	1.0541
	Ector County, TX	
36260	Ogden-Clearfield, UT	0.9447
	Davis County, UT	
	Morgan County, UT	
	Weber County, UT	

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
36420	Oklahoma City, OK	0.9253
	Canadian County, OK	
	Cleveland County, OK	
	Grady County, OK	
	Lincoln County, OK	
	Logan County, OK	
	McClain County, OK	
	Oklahoma County, OK	
36500	Olympia, WA	1.2084
	Thurston County, WA	
36540	Omaha-Council Bluffs, NE-IA	1.0036
	Harrison County, IA	
	Mills County, IA	
	Pottawattamie County, IA	
	Cass County, NE	
	Douglas County, NE	
	Sarpy County, NE	
	Saunders County, NE	
	Washington County, NE	
36740	Orlando, FL	0.9684
	Lake County, FL	
	Orange County, FL	
	Osceola County, FL	
	Seminole County, FL	
36780	Oshkosh-Neenah, WI	1.0026
	Winnebago County, WI	
36980	Owensboro, KY	0.9082
	Daviess County, KY	
	Hancock County, KY	
	McLean County, KY	
37100	Oxnard-Thousand Oaks-Ventura, CA	1.2441
	Ventura County, CA	
37340	Palm Bay-Melbourne-Titusville, FL	0.9788
	Brevard County, FL	
37380	Palm Coast, FL	0.9389
	Flagler County, FL	
37460	Panama City-Lynn Haven, FL	0.8726
	Bay County, FL	
37620	Parkersburg-Marietta, WV-OH	0.8508
	Washington County, OH	
	Pleasants County, WV	
	Wirt County, WV	
	Wood County, WV	
37700	Pascagoula, MS	0.9077
	George County, MS	
	Jackson County, MS	
37764	Peabody, MA	1.1179
	Essex County, MA	
37860	Pensacola-Ferry Pass-Brent, FL	0.8692
	Escambia County, FL	
	Santa Rosa County, FL	
37900	Peoria, IL	0.9761
	Marshall County, IL	
	Peoria County, IL	
	Stark County, IL	
	Tazewell County, IL	
	Woodford County, IL	
37964	Philadelphia, PA	1.1468
	Bucks County, PA	
	Chester County, PA	
	Delaware County, PA	
	Montgomery County, PA	
	Philadelphia County, PA	
38060	Phoenix-Mesa-Scottsdale, AZ	1.0774
	Maricopa County, AZ	
	Pinal County, AZ	
38220	Pine Bluff, AR	0.8229
	Cleveland County, AR	
	Jefferson County, AR	
	Lincoln County, AR	
38300	Pittsburgh, PA	0.8949

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
	Allegheny County, PA	
	Armstrong County, PA	
	Beaver County, PA	
	Butler County, PA	
	Fayette County, PA	
	Washington County, PA	
	Westmoreland County, PA	
38340	Pittsfield, MA	1.0592
	Berkshire County, MA	
38540	Pocatello, ID	0.9935
	Bannock County, ID	
	Power County, ID	
38660	Ponce, PR	0.5118
	Juana Díaz Municipio, PR	
	Ponce Municipio, PR	
	Villalba Municipio, PR	
38860	Portland-South Portland-Biddeford, ME	1.0541
	Cumberland County, ME	
	Sagadahoc County, ME	
	York County, ME	
38900	Portland-Vancouver-Beaverton, OR-WA	1.2069
	Clackamas County, OR	
	Columbia County, OR	
	Multnomah County, OR	
	Washington County, OR	
	Yamhill County, OR	
	Clark County, WA	
	Skamania County, WA	
38940	Port St. Lucie, FL	1.0514
	Martin County, FL	
	St. Lucie County, FL	
39100	Poughkeepsie-Newburgh-Middletown, NY	1.1528
	Dutchess County, NY	
	Orange County, NY	
39140	Prescott, AZ	1.0518
	Yavapai County, AZ	
39300	Providence-New Bedford-Fall River, RI-MA	1.1099
	Bristol County, MA	
	Bristol County, RI	
	Kent County, RI	
	Newport County, RI	
	Providence County, RI	
	Washington County, RI	
39340	Provo-Orem, UT	1.0032
	Juab County, UT	
	Utah County, UT	
39380	Pueblo, CO	0.9291
	Pueblo County, CO	
39460	Punta Gorda, FL	0.9714
	Charlotte County, FL	
39540	Racine, WI	0.9970
	Racine County, WI	
39580	Raleigh-Cary, NC	1.0328
	Franklin County, NC	
	Johnston County, NC	
	Wake County, NC	
39660	Rapid City, SD	0.9249
	Meade County, SD	
	Pennington County, SD	
39740	Reading, PA	0.9821
	Berks County, PA	
39820	Redding, CA	1.4214
	Shasta County, CA	
39900	Reno-Sparks, NV	1.1247
	Storey County, NV	
	Washoe County, NV	
40060	Richmond, VA	0.9893
	Amelia County, VA	
	Caroline County, VA	
	Charles City County, VA	
	Chesterfield County, VA	

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
	Cumberland County, VA	
	Dinwiddie County, VA	
	Goochland County, VA	
	Hanover County, VA	
	Henrico County, VA	
	King and Queen County, VA	
	King William County, VA	
	Louisa County, VA	
	New Kent County, VA	
	Powhatan County, VA	
	Prince George County, VA	
	Sussex County, VA	
	Colonial Heights City, VA	
	Hopewell City, VA	
	Petersburg City, VA	
	Richmond City, VA	
40140	Riverside-San Bernardino-Ontario, CA	1.1652
	Riverside County, CA	
	San Bernardino County, CA	
40220	Roanoke, VA	0.9123
	Botetourt County, VA	
	Craig County, VA	
	Franklin County, VA	
	Roanoke County, VA	
	Roanoke City, VA	
	Salem City, VA	
40340	Rochester, MN	1.1289
	Dodge County, MN	
	Olmsted County, MN	
	Wabasha County, MN	
40380	Rochester, NY	0.9298
	Livingston County, NY	
	Monroe County, NY	
	Ontario County, NY	
	Orleans County, NY	
	Wayne County, NY	
40420	Rockford, IL	1.0302
	Boone County, IL	
	Winnebago County, IL	
40484	Rockingham County-Strafford County, NH	1.0613
	Rockingham County, NH	
	Strafford County, NH	
40580	Rocky Mount, NC	0.9448
	Edgecombe County, NC	
	Nash County, NC	
40660	Rome, GA	0.9491
	Floyd County, GA	
40900	Sacramento—Arden-Arcade—Roseville, CA	1.4176
	El Dorado County, CA	
	Placer County, CA	
	Sacramento County, CA	
	Yolo County, CA	
40980	Saginaw-Saginaw Township North, MI	0.9250
	Saginaw County, MI	
41060	St. Cloud, MN	1.1073
	Benton County, MN	
	Stearns County, MN	
41100	St. George, UT	0.9823
	Washington County, UT	
41140	St. Joseph, MO-KS	0.9197
	Doniphan County, KS	
	Andrew County, MO	
	Buchanan County, MO	
	DeKalb County, MO	
41180	St. Louis, MO-IL	0.9472
	Bond County, IL	
	Calhoun County, IL	
	Clinton County, IL	
	Jersey County, IL	
	Macoupin County, IL	
	Madison County, IL	

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
	Monroe County, IL	
	St. Clair County, IL	
	Crawford County, MO	
	Franklin County, MO	
	Jefferson County, MO	
	Lincoln County, MO	
	St. Charles County, MO	
	St. Louis County, MO	
	Warren County, MO	
	Washington County, MO	
	St. Louis City, MO	
41420	Salem, OR	1.1097
	Marion County, OR	
	Polk County, OR	
41500	Salinas, CA	1.5509
	Monterey County, CA	
41540	Salisbury, MD	0.9441
	Somerset County, MD	
	Wicomico County, MD	
41620	Salt Lake City, UT	0.9866
	Salt Lake County, UT	
	Summit County, UT	
	Tooele County, UT	
41660	San Angelo, TX	0.9005
	Irion County, TX	
	Tom Green County, TX	
41700	San Antonio, TX	0.9273
	Atascosa County, TX	
	Bandera County, TX	
	Bexar County, TX	
	Comal County, TX	
	Guadalupe County, TX	
	Kendall County, TX	
	Medina County, TX	
	Wilson County, TX	
41740	San Diego-Carlsbad-San Marcos, CA	1.2063
	San Diego County, CA	
41780	Sandusky, OH	0.9260
	Erie County, OH	
41884	San Francisco-San Mateo-Redwood City, CA	1.5950
	Marin County, CA	
	San Francisco County, CA	
	San Mateo County, CA	
41900	San Germán-Cabo Rojo, PR	0.5438
	Cabo Rojo Municipio, PR	
	Lajas Municipio, PR	
	Sabana Grande Municipio, PR	
	San Germán Municipio, PR	
41940	San Jose-Sunnyvale-Santa Clara, CA	1.6517
	San Benito County, CA	
	Santa Clara County, CA	
41980	San Juan-Caguas-Guaynabo, PR	0.5207
	Aguas Buenas Municipio, PR	
	Aibonito Municipio, PR	
	Arecibo Municipio, PR	
	Barceloneta Municipio, PR	
	Barranquitas Municipio, PR	
	Bayamón Municipio, PR	
	Caguas Municipio, PR	
	Camuy Municipio, PR	
	Canóvanas Municipio, PR	
	Carolina Municipio, PR	
	Cataño Municipio, PR	
	Cayey Municipio, PR	
	Ciales Municipio, PR	
	Cidra Municipio, PR	
	Comerío Municipio, PR	
	Corozal Municipio, PR	
	Dorado Municipio, PR	
	Florida Municipio, PR	
	Guaynabo Municipio, PR	

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
	Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR	
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.3109
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2351
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.2296
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.6923
42140	Santa Fe, NM Santa Fe County, NM	1.1267
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.5426
42260	Sarasota-Bradenton-Venice, FL Manatee County, FL Sarasota County, FL	1.0427
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9585
42540	Scranton—Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8877
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.2147
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9880
43100	Sheboygan, WI Sheboygan County, WI	0.9421
43300	Sherman-Denison, TX Grayson County, TX	0.8733
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8897
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9711
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	1.0038
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	1.0095

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
43900	Spartanburg, SC	0.9890
	Spartanburg County, SC	
44060	Spokane, WA	1.0975
	Spokane County, WA	
44100	Springfield, IL	0.9388
	Menard County, IL	
	Sangamon County, IL	
44140	Springfield, MA	1.0881
	Franklin County, MA	
	Hampden County, MA	
	Hampshire County, MA	
44180	Springfield, MO	0.9127
	Christian County, MO	
	Dallas County, MO	
	Greene County, MO	
	Polk County, MO	
	Webster County, MO	
44220	Springfield, OH	0.9126
	Clark County, OH	
44300	State College, PA	0.9204
	Centre County, PA	
44700	Stockton, CA	1.2444
	San Joaquin County, CA	
44940	Sumter, SC	0.9026
	Sumter County, SC	
45060	Syracuse, NY	1.0402
	Madison County, NY	
	Onondaga County, NY	
	Oswego County, NY	
45104	Tacoma, WA	1.1604
	Pierce County, WA	
45220	Tallahassee, FL	0.9473
	Gadsden County, FL	
	Jefferson County, FL	
	Leon County, FL	
	Wakulla County, FL	
45300	Tampa-St. Petersburg-Clearwater, FL	0.9468
	Hernando County, FL	
	Hillsborough County, FL	
	Pasco County, FL	
	Pinellas County, FL	
45460	Terre Haute, IN	0.9243
	Clay County, IN	
	Sullivan County, IN	
	Vermillion County, IN	
	Vigo County, IN	
45500	Texarkana, TX-Texarkana, AR	0.8156
	Miller County, AR	
	Bowie County, TX	
45780	Toledo, OH	0.9900
	Fulton County, OH	
	Lucas County, OH	
	Ottawa County, OH	
	Wood County, OH	
45820	Topeka, KS	0.8962
	Jackson County, KS	
	Jefferson County, KS	
	Osage County, KS	
	Shawnee County, KS	
	Wabaunsee County, KS	
45940	Trenton-Ewing, NJ	1.1231
	Mercer County, NJ	
46060	Tucson, AZ	0.9704
	Pima County, AZ	
46140	Tulsa, OK	0.8754
	Creek County, OK	
	Okmulgee County, OK	
	Osage County, OK	
	Pawnee County, OK	
	Rogers County, OK	
	Tulsa County, OK	

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
	Wagoner County, OK	
46220	Tuscaloosa, AL	0.8716
	Greene County, AL	
	Hale County, AL	
	Tuscaloosa County, AL	
46340	Tyler, TX	0.9567
	Smith County, TX	
46540	Utica-Rome, NY	0.8908
	Herkimer County, NY	
	Oneida County, NY	
46660	Valdosta, GA	0.8500
	Brooks County, GA	
	Echols County, GA	
	Lanier County, GA	
	Lowndes County, GA	
46700	Vallejo-Fairfield, CA	1.5395
	Solano County, CA	
47020	Victoria, TX	0.8715
	Calhoun County, TX	
	Goliad County, TX	
	Victoria County, TX	
47220	Vineland-Millville-Bridgeton, NJ	1.0637
	Cumberland County, NJ	
47260	Virginia Beach-Norfolk-Newport News, VA-NC	0.9256
	Currituck County, NC	
	Gloucester County, VA	
	Isle of Wight County, VA	
	James City County, VA	
	Mathews County, VA	
	Surry County, VA	
	York County, VA	
	Chesapeake City, VA	
	Hampton City, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	
47300	Visalia-Porterville, CA	1.0592
	Tulare County, CA	
47380	Waco, TX	0.8941
	McLennan County, TX	
47580	Warner Robins, GA	0.9582
	Houston County, GA	
47644	Warren-Troy-Farmington Hills, MI	1.0498
	Lapeer County, MI	
	Livingston County, MI	
	Macomb County, MI	
	Oakland County, MI	
	St. Clair County, MI	
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	1.1394
	District of Columbia, DC	
	Calvert County, MD	
	Charles County, MD	
	Prince George's County, MD	
	Arlington County, VA	
	Clarke County, VA	
	Fairfax County, VA	
	Fauquier County, VA	
	Loudoun County, VA	
	Prince William County, VA	
	Spotsylvania County, VA	
	Stafford County, VA	
	Warren County, VA	
	Alexandria City, VA	
	Fairfax City, VA	
	Falls Church City, VA	
	Fredericksburg City, VA	
	Manassas City, VA	

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
	Manassas Park City, VA	
	Jefferson County, WV	
47940	Waterloo-Cedar Falls, IA	0.8942
	Black Hawk County, IA	
	Bremer County, IA	
	Grundy County, IA	
48140	Wausau, WI	1.0160
	Marathon County, WI	
48260	Weirton-Steubenville, WV-OH	0.8318
	Jefferson County, OH	
	Brooke County, WV	
	Hancock County, WV	
48300	Wenatchee, WA	1.2039
	Chelan County, WA	
	Douglas County, WA	
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	1.0211
	Palm Beach County, FL	
48540	Wheeling, WV-OH	0.8000
	Belmont County, OH	
	Marshall County, WV	
	Ohio County, WV	
48620	Wichita, KS	0.9512
	Butler County, KS	
	Harvey County, KS	
	Sedgwick County, KS	
	Sumner County, KS	
48660	Wichita Falls, TX	0.8314
	Archer County, TX	
	Clay County, TX	
	Wichita County, TX	
48700	Williamsport, PA	0.8443
	Lycoming County, PA	
48864	Wilmington, DE-MD-NJ	1.1362
	New Castle County, DE	
	Cecil County, MD	
	Salem County, NJ	
48900	Wilmington, NC	0.9878
	Brunswick County, NC	
	New Hanover County, NC	
	Pender County, NC	
49020	Winchester, VA-WV	1.0406
	Frederick County, VA	
	Winchester City, VA	
	Hampshire County, WV	
49180	Winston-Salem, NC	0.9571
	Davie County, NC	
	Forsyth County, NC	
	Stokes County, NC	
	Yadkin County, NC	
49340	Worcester, MA	1.1848
	Worcester County, MA	
49420	Yakima, WA	1.0777
	Yakima County, WA	
49500	Yauco, PR	0.3777
	Guánica Municipio, PR	
	Guayanilla Municipio, PR	
	Peñuelas Municipio, PR	
	Yauco Municipio, PR	
49620	York-Hanover, PA	0.9824
	York County, PA	
49660	Youngstown-Warren-Boardman, OH-PA	0.9449
	Mahoning County, OH	
	Trumbull County, OH	
	Mercer County, PA	
49700	Yuba City, CA	1.1290
	Sutter County, CA	
	Yuba County, CA	
49740	Yuma, AZ	0.9959

ADDENDUM A—FINAL HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA—FY 2009—Continued

CBSA code	Urban area (constituent counties) [2]	Wage index [1]
	Yuma County, AZ	

[1] Wage index values are based on FY 2004 hospital cost report data before reclassification. These data form the basis for the raw pre-floor, pre-reclassified hospital wage index. The budget neutrality adjustment or the hospice floor is then applied to the raw pre-floor, pre-reclassified hospital wage index to derive the hospice wage index. Wage index values greater than or equal to 0.8 are subject to a budget neutrality adjustment. The hospice floor calculation is as follows: Wage index values below 0.8 are adjusted to be the greater of either (a) the 25 percent reduced budget neutrality adjustment OR (b) the minimum of the raw pre-floor, pre-reclassified hospital wage index value × 1.15, or 0.8000. For the final FY 2009 hospice wage index, the budget neutrality adjustment was reduced by 25 percent.

[2] This column lists each CBSA area name and each county or county equivalent, in the CBSA area. Counties not listed in this table are considered to be rural areas. Wage index values for rural areas are found in Addendum B.

[3] Because there are no hospitals in this CBSA, the wage index value is calculated by taking the average of all other urban CBSAs in Georgia.

ADDENDUM B—FINAL HOSPICE WAGE INDEX FOR RURAL AREAS BY CBSA—FY 2009

CBSA code	Nonurban area	Wage index
1	Alabama	0.8000
2	Alaska	1.2711
3	Arizona	0.8900
4	Arkansas	0.8000
5	California	1.2620
6	Colorado	1.0186
7	Connecticut	1.1672
8	Delaware	1.0210
10	Florida	0.8886
11	Georgia	0.8040
12	Hawaii	1.1139
13	Idaho	0.8314
14	Illinois	0.8749
15	Indiana	0.9002
16	Iowa	0.8992
17	Kansas	0.8378
18	Kentucky	0.8180
19	Louisiana	0.8000
20	Maine	0.8897
21	Maryland	0.9483

ADDENDUM B—FINAL HOSPICE WAGE INDEX FOR RURAL AREAS BY CBSA—FY 2009—Continued

CBSA code	Nonurban area	Wage index
22	Massachusetts [1]	1.2164
23	Michigan	0.9398
24	Minnesota	0.9530
25	Mississippi	0.8083
26	Missouri	0.8324
27	Montana	0.8795
28	Nebraska	0.9289
29	Nevada	0.9733
30	New Hampshire	1.0990
31	New Jersey [2]	
32	New Mexico	0.9384
33	New York	0.8679
34	North Carolina	0.9030
35	North Dakota	0.8000
36	Ohio	0.9147
37	Oklahoma	0.8000
38	Oregon	1.0398
39	Pennsylvania	0.8802
40	Puerto Rico [3]	0.4654
41	Rhode Island [2]	

ADDENDUM B—FINAL HOSPICE WAGE INDEX FOR RURAL AREAS BY CBSA—FY 2009—Continued

CBSA code	Nonurban area	Wage index
42	South Carolina	0.9086
43	South Dakota	0.8974
44	Tennessee	0.8107
45	Texas	0.8364
46	Utah	0.8519
47	Vermont	1.0412
48	Virgin Islands	0.7855
49	Virginia	0.8288
50	Washington	1.0769
51	West Virginia	0.8000
52	Wisconsin	1.0147
53	Wyoming	0.9748
65	Guam	1.0089

[1] There are no hospitals in the rural areas of Massachusetts, so the wage index value used is the average wage index value for the contiguous counties.

[2] There are no rural areas in this state.

[3] Wage index values are obtained using the methodology described in the rule.

ADDENDUM C—COMPARISON OF RAW PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX VALUES USED AS INPUT VALUES TO DERIVE THE FY 2008 AND FY 2009 HOSPICE WAGE INDICES

[For illustrative purposes only]

		FY2008	FY2009	FY09–FY08	Percent chng
	Rural Area				
1	Alabama	0.7591	0.7533	−0.0058	−0.76
2	Alaska	1.0661	1.2109	0.1448	13.58
3	Arizona	0.8908	0.8479	−0.0429	−4.82
4	Arkansas	0.7307	0.7371	0.0064	0.88
5	California	1.1454	1.2023	0.0569	4.97
6	Colorado	0.9325	0.9704	0.0379	4.06
7	Connecticut	1.1709	1.1119	−0.0590	−5.04
8	Delaware	0.9705	0.9727	0.0022	0.23
10	Florida	0.8594	0.8465	−0.0129	−1.50
11	Georgia	0.7593	0.7659	0.0066	0.87
12	Hawaii	1.0448	1.0612	0.0164	1.57
13	Idaho	0.8120	0.7920	−0.0200	−2.46
14	Illinois	0.8320	0.8335	0.0015	0.18
15	Indiana	0.8538	0.8576	0.0038	0.45
16	Iowa	0.8681	0.8566	−0.0115	−1.32
17	Kansas	0.7998	0.7981	−0.0017	−0.21
18	Kentucky	0.7768	0.7793	0.0025	0.32
19	Louisiana	0.7438	0.7373	−0.0065	−0.87
20	Maine	0.8443	0.8476	0.0033	0.39
21	Maryland	0.8926	0.9034	0.0108	1.21
22	Massachusetts	1.1661	1.1589	−0.0072	−0.62
23	Michigan	0.9062	0.8953	−0.0109	−1.20

ADDENDUM C—COMPARISON OF RAW PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX VALUES USED AS INPUT VALUES TO DERIVE THE FY 2008 AND FY 2009 HOSPICE WAGE INDICES—Continued

[For illustrative purposes only]

		FY2008	FY2009	FY09–FY08	Percent chng
24	Minnesota	0.9153	0.9079	−0.0074	−0.81
25	Mississippi	0.7738	0.7700	−0.0038	−0.49
26	Missouri	0.7927	0.7930	0.0003	0.04
27	Montana	0.8590	0.8379	−0.0211	−2.46
28	Nebraska	0.8677	0.8849	0.0172	1.98
29	Nevada	0.8944	0.9272	0.0328	3.67
30	New Hampshire	1.0853	1.0470	−0.0383	−3.53
32	New Mexico	0.8332	0.8940	0.0608	7.30
33	New York	0.8232	0.8268	0.0036	0.44
34	North Carolina	0.8588	0.8603	0.0015	0.17
35	North Dakota	0.7215	0.7182	−0.0033	−0.46
36	Ohio	0.8658	0.8714	0.0056	0.65
37	Oklahoma	0.7629	0.7492	−0.0137	−1.80
38	Oregon	0.9753	0.9906	0.0153	1.57
39	Pennsylvania	0.8320	0.8385	0.0065	0.78
40	Puerto Rico	0.4047	0.4047	0.0000	0.00
42	South Carolina	0.8566	0.8656	0.0090	1.05
43	South Dakota	0.8480	0.8549	0.0069	0.81
44	Tennessee	0.7827	0.7723	−0.0104	−1.33
45	Texas	0.7965	0.7968	0.0003	0.04
46	Utah	0.8140	0.8116	−0.0024	−0.29
47	Vermont	0.9744	0.9919	0.0175	1.80
48	Virgin Islands	0.8467	0.6830	−0.1637	−19.33
49	Virginia	0.7940	0.7896	−0.0044	−0.55
50	Washington	1.0263	1.0259	−0.0004	−0.04
51	West Virginia	0.7607	0.7454	−0.0153	−2.01
52	Wisconsin	0.9553	0.9667	0.0114	1.19
53	Wyoming	0.9295	0.9287	−0.0008	−0.09
65	Guam	0.9611	0.9611	0.0000	0.00
CBSA	**Urban Area**				
10180	Abilene, TX	0.8000	0.7957	−0.0043	−0.54
10380	Aguadilla-Isabela-San Sebastián, PR	0.3915	0.3448	−0.0467	−11.93
10420	Akron, OH	0.8654	0.8794	0.0140	1.62
10500	Albany, GA	0.8991	0.8514	−0.0477	−5.31
10580	Albany-Schenectady-Troy, NY	0.8720	0.8588	−0.0132	−1.51
10740	Albuquerque, NM	0.9458	0.9554	0.0096	1.02
10780	Alexandria, LA	0.8006	0.7979	−0.0027	−0.34
10900	Allentown-Bethlehem-Easton, PA-NJ	0.9947	0.9865	−0.0082	−0.82
11020	Altoona, PA	0.8812	0.8618	−0.0194	−2.20
11100	Amarillo, TX	0.9169	0.9116	−0.0053	−0.58
11180	Ames, IA	0.9760	1.0046	0.0286	2.93
11260	Anchorage, AK	1.2023	1.1913	−0.0110	−0.91
11300	Anderson, IN	0.8681	0.8827	0.0146	1.68
11340	Anderson, SC	0.9017	0.9086	0.0069	0.77
11460	Ann Arbor, MI	1.0826	1.0539	−0.0287	−2.65
11500	Anniston-Oxford, AL	0.7770	0.7926	0.0156	2.01
11540	Appleton, WI	0.9455	0.9598	0.0143	1.51
11700	Asheville, NC	0.9216	0.9185	−0.0031	−0.34
12020	Athens-Clarke County, GA	0.9856	1.0517	0.0661	6.71
12060	Atlanta-Sandy Springs-Marietta, GA	0.9762	0.9828	0.0066	0.68
12100	Atlantic City, NJ	1.1831	1.2198	0.0367	3.10
12220	Auburn-Opelika, AL	0.8096	0.8090	−0.0006	−0.07
12260	Augusta-Richmond County, GA-SC	0.9667	0.9645	−0.0022	−0.23
12420	Austin-Round Rock, TX	0.9344	0.9544	0.0200	2.14
12540	Bakersfield, CA	1.0725	1.1051	0.0326	3.04
12580	Baltimore-Towson, MD	1.0088	1.0134	0.0046	0.46
12620	Bangor, ME	0.9711	0.9978	0.0267	2.75
12700	Barnstable Town, MA	1.2539	1.2603	0.0064	0.51
12940	Baton Rouge, LA	0.8084	0.8034	−0.0050	−0.62
12980	Battle Creek, MI	0.9762	1.0179	0.0417	4.27
13020	Bay City, MI	0.9251	0.8897	−0.0354	−3.83
13140	Beaumont-Port Arthur, TX	0.8595	0.8531	−0.0064	−0.74
13380	Bellingham, WA	1.1104	1.1474	0.0370	3.33
13460	Bend, OR	1.0743	1.0942	0.0199	1.85
13644	Bethesda-Gaithersburg-Frederick, MD	1.0903	1.0511	−0.0392	−3.60
13740	Billings, MT	0.8712	0.8666	−0.0046	−0.53
13780	Binghamton, NY	0.8786	0.8949	0.0163	1.86

ADDENDUM C—COMPARISON OF RAW PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX VALUES USED AS INPUT VALUES TO DERIVE THE FY 2008 AND FY 2009 HOSPICE WAGE INDICES—Continued

[For illustrative purposes only]

		FY2008	FY2009	FY09–FY08	Percent chng
13820	Birmingham-Hoover, AL	0.8894	0.8898	0.0004	0.04
13900	Bismarck, ND	0.7240	0.7225	−0.0015	−0.21
13980	Blacksburg-Christiansburg-Radford, VA	0.8213	0.8192	−0.0021	−0.26
14020	Bloomington, IN	0.8533	0.8915	0.0382	4.48
14060	Bloomington-Normal, IL	0.8944	0.9325	0.0381	4.26
14260	Boise City-Nampa, ID	0.9401	0.9465	0.0064	0.68
14484	Boston-Quincy, MA	1.1679	1.1792	0.0113	0.97
14500	Boulder, CO	1.0350	1.0426	0.0076	0.73
14540	Bowling Green, KY	0.8148	0.8159	0.0011	0.14
14740	Bremerton-Silverdale, WA	1.0913	1.0904	−0.0009	−0.08
14860	Bridgeport-Stamford-Norwalk, CT	1.2659	1.2735	0.0076	0.60
15180	Brownsville-Harlingen, TX	0.9430	0.8914	−0.0516	−5.47
15260	Brunswick, GA	1.0164	0.9475	−0.0689	−6.78
15380	Buffalo-Niagara Falls, NY	0.9424	0.9568	0.0144	1.53
15500	Burlington, NC	0.8674	0.8747	0.0073	0.84
15540	Burlington-South Burlington, VT	0.9474	0.9660	0.0186	1.96
15764	Cambridge-Newton-Framingham, MA	1.0970	1.1215	0.0245	2.23
15804	Camden, NJ	1.0392	1.0411	0.0019	0.18
15940	Canton-Massillon, OH	0.9031	0.8935	−0.0096	−1.06
15980	Cape Coral-Fort Myers, FL	0.9342	0.9396	0.0054	0.58
16180	Carson City, NV	1.0025	1.0003	−0.0022	−0.22
16220	Casper, WY	0.9145	0.9385	0.0240	2.62
16300	Cedar Rapids, IA	0.8888	0.8852	−0.0036	−0.41
16580	Champaign-Urbana, IL	0.9644	0.9392	−0.0252	−2.61
16620	Charleston, WV	0.8542	0.8289	−0.0253	−2.96
16700	Charleston-North Charleston, SC	0.9145	0.9124	−0.0021	−0.23
16740	Charlotte-Gastonia-Concord, NC-SC	0.9554	0.9520	−0.0034	−0.36
16820	Charlottesville, VA	1.0125	0.9277	−0.0848	−8.38
16860	Chattanooga, TN-GA	0.8948	0.8994	0.0046	0.51
16940	Cheyenne, WY	0.9060	0.9308	0.0248	2.74
16974	Chicago-Naperville-Joliet, IL	1.0751	1.0715	−0.0036	−0.33
17020	Chico, CA	1.1053	1.1290	0.0237	2.14
17140	Cincinnati-Middletown, OH-KY-IN	0.9601	0.9784	0.0183	1.91
17300	Clarksville, TN-KY	0.8436	0.8251	−0.0185	−2.19
17420	Cleveland, TN	0.8109	0.8052	−0.0057	−0.70
17460	Cleveland-Elyria-Mentor, OH	0.9400	0.9339	−0.0061	−0.65
17660	Coeur d'Alene, ID	0.9344	0.9532	0.0188	2.01
17780	College Station-Bryan, TX	0.9045	0.9358	0.0313	3.46
17820	Colorado Springs, CO	0.9701	0.9719	0.0018	0.19
17860	Columbia, MO	0.8542	0.8658	0.0116	1.36
17900	Columbia, SC	0.8933	0.8800	−0.0133	−1.49
17980	Columbus, GA-AL	0.8239	0.8729	0.0490	5.95
18020	Columbus, IN	0.9318	0.9537	0.0219	2.35
18140	Columbus, OH	1.0107	1.0085	−0.0022	−0.22
18580	Corpus Christi, TX	0.8564	0.8588	0.0024	0.28
18700	Corvallis, OR	1.1546	1.0959	−0.0587	−5.08
19060	Cumberland, MD-WV	0.8446	0.8294	−0.0152	−1.80
19124	Dallas-Plano-Irving, TX	1.0075	0.9915	−0.0160	−1.59
19140	Dalton, GA	0.9093	0.8760	−0.0333	−3.66
19180	Danville, IL	0.9266	0.8957	−0.0309	−3.33
19260	Danville, VA	0.8451	0.8240	−0.0211	−2.50
19340	Davenport-Moline-Rock Island, IA-IL	0.8846	0.8830	−0.0016	−0.18
19380	Dayton, OH	0.9037	0.9190	0.0153	1.69
19460	Decatur, AL	0.8159	0.7885	−0.0274	−3.36
19500	Decatur, IL	0.8172	0.8074	−0.0098	−1.20
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.9263	0.9031	−0.0232	−2.50
19740	Denver-Aurora, CO	1.0930	1.0718	−0.0212	−1.94
19780	Des Moines-West Des Moines, IA	0.9214	0.9226	0.0012	0.13
19804	Detroit-Livonia-Dearborn, MI	1.0281	0.9999	−0.0282	−2.74
20020	Dothan, AL	0.7381	0.7270	−0.0111	−1.50
20100	Dover, DE	0.9847	1.0099	0.0252	2.56
20220	Dubuque, IA	0.9133	0.9058	−0.0075	−0.82
20260	Duluth, MN-WI	1.0042	0.9975	−0.0067	−0.67
20500	Durham, NC	0.9826	0.9816	−0.0010	−0.10
20740	Eau Claire, WI	0.9630	0.9475	−0.0155	−1.61
20764	Edison, NJ	1.1190	1.1181	−0.0009	−0.08
20940	El Centro, CA	0.9076	0.8914	−0.0162	−1.78
21060	Elizabethtown, KY	0.8697	0.8711	0.0014	0.16
21140	Elkhart-Goshen, IN	0.9426	0.9611	0.0185	1.96

ADDENDUM C—COMPARISON OF RAW PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX VALUES USED AS INPUT VALUES TO DERIVE THE FY 2008 AND FY 2009 HOSPICE WAGE INDICES—Continued

[For illustrative purposes only]

		FY2008	FY2009	FY09–FY08	Percent chng
21300	Elmira, NY	0.8240	0.8264	0.0024	0.29
21340	El Paso, TX	0.9053	0.8989	−0.0064	−0.71
21500	Erie, PA	0.8827	0.8495	−0.0332	−3.76
21604	Essex County, MA	1.0418	.....	.....	.....
21660	Eugene-Springfield, OR	1.0876	1.0932	0.0056	0.51
21780	Evansville, IN-KY	0.9071	0.8662	−0.0409	−4.51
21820	Fairbanks, AK	1.1059	1.1050	−0.0009	−0.08
21940	Fajardo, PR	0.4036	0.4375	0.0339	8.40
22020	Fargo, ND-MN	0.8250	0.8042	−0.0208	−2.52
22140	Farmington, NM	0.8589	0.9587	0.0998	11.62
22180	Fayetteville, NC	0.8945	0.9368	0.0423	4.73
22220	Fayetteville-Springdale-Rogers, AR-MO	0.8865	0.8742	−0.0123	−1.39
22380	Flagstaff, AZ	1.1601	1.1687	0.0086	0.74
22420	Flint, MI	1.0969	1.1220	0.0251	2.29
22500	Florence, SC	0.8388	0.8249	−0.0139	−1.66
22520	Florence-Muscle Shoals, AL	0.7843	0.7680	−0.0163	−2.08
22540	Fond du Lac, WI	1.0063	0.9667	−0.0396	−3.94
22660	Fort Collins-Loveland, CO	0.9544	0.9897	0.0353	3.70
22744	Ft Lauderdale-Pompano Beach-Deerfield, FL	1.0133	1.0229	0.0096	0.95
22900	Fort Smith, AR-OK	0.7731	0.7933	0.0202	2.61
23020	Fort Walton Beach-Crestview-Destin, FL	0.8643	0.8743	0.0100	1.16
23060	Fort Wayne, IN	0.9517	0.9284	−0.0233	−2.45
23104	Fort Worth-Arlington, TX	0.9569	0.9693	0.0124	1.30
23420	Fresno, CA	1.0943	1.0993	0.0050	0.46
23460	Gadsden, AL	0.8066	0.8159	0.0093	1.15
23540	Gainesville, FL	0.9277	0.9196	−0.0081	−0.87
23580	Gainesville, GA	0.8958	0.9216	0.0258	2.88
23844	Gary, IN	0.9334	0.9224	−0.0110	−1.18
24020	Glens Falls, NY	0.8324	0.8256	−0.0068	−0.82
24140	Goldsboro, NC	0.9171	0.9288	0.0117	1.28
24220	Grand Forks, ND-MN	0.7949	0.7881	−0.0068	−0.86
24300	Grand Junction, CO	0.9668	0.9864	0.0196	2.03
24340	Grand Rapids-Wyoming, MI	0.9455	0.9315	−0.0140	−1.48
24500	Great Falls, MT	0.8598	0.8675	0.0077	0.90
24540	Greeley, CO	0.9602	0.9658	0.0056	0.58
24580	Green Bay, WI	0.9787	0.9727	−0.0060	−0.61
24660	Greensboro-High Point, NC	0.8866	0.9010	0.0144	1.62
24780	Greenville, NC	0.9432	0.9402	−0.0030	−0.32
24860	Greenville, SC	0.9804	0.9860	0.0056	0.57
25020	Guayama, PR	0.3235	0.3064	−0.0171	−5.29
25060	Gulfport-Biloxi, MS	0.8915	0.8773	−0.0142	−1.59
25180	Hagerstown-Martinsburg, MD-WV	0.9038	0.9013	−0.0025	−0.28
25260	Hanford-Corcoran, CA	1.0282	1.0499	0.0217	2.11
25420	Harrisburg-Carlisle, PA	0.9402	0.9280	−0.0122	−1.30
25500	Harrisonburg, VA	0.9073	0.8867	−0.0206	−2.27
25540	Hartford-West Hartford-East Hartford, CT	1.0894	1.0959	0.0065	0.60
25620	Hattiesburg, MS	0.7430	0.7366	−0.0064	−0.86
25860	Hickory-Lenoir-Morganton, NC	0.9010	0.9028	0.0018	0.20
25980	Hinesville-Fort Stewart, GA	0.9178	0.9187	0.0009	0.10
26100	Holland-Grand Haven, MI	0.9163	0.9006	−0.0157	−1.71
26180	Honolulu, HI	1.1096	1.1556	0.0460	4.15
26300	Hot Springs, AR	0.8782	0.9109	0.0327	3.72
26380	Houma-Bayou Cane-Thibodaux, LA	0.8082	0.7892	−0.0190	−2.35
26420	Houston-Sugar Land-Baytown, TX	1.0008	0.9939	−0.0069	−0.69
26580	Huntington-Ashland, WV-KY-OH	0.8997	0.9041	0.0044	0.49
26620	Huntsville, AL	0.9007	0.9146	0.0139	1.54
26820	Idaho Falls, ID	0.9088	0.9264	0.0176	1.94
26900	Indianapolis-Carmel, IN	0.9895	0.9844	−0.0051	−0.52
26980	Iowa City, IA	0.9714	0.9568	−0.0146	−1.50
27060	Ithaca, NY	0.9928	0.9630	−0.0298	−3.00
27100	Jackson, MI	0.9560	0.9329	−0.0231	−2.42
27140	Jackson, MS	0.8271	0.8011	−0.0260	−3.14
27180	Jackson, TN	0.8853	0.8676	−0.0177	−2.00
27260	Jacksonville, FL	0.9165	0.9021	−0.0144	−1.57
27340	Jacksonville, NC	0.8231	0.8079	−0.0152	−1.85
27500	Janesville, WI	0.9655	0.9702	0.0047	0.49
27620	Jefferson City, MO	0.8332	0.8478	0.0146	1.75
27740	Johnson City, TN	0.8043	0.7677	−0.0366	−4.55
27780	Johnstown, PA	0.8620	0.7543	−0.1077	−12.49

ADDENDUM C—COMPARISON OF RAW PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX VALUES USED AS INPUT VALUES TO DERIVE THE FY 2008 AND FY 2009 HOSPICE WAGE INDICES—Continued

[For illustrative purposes only]

		FY2008	FY2009	FY09–FY08	Percent chng
27860	Jonesboro, AR	0.7662	0.7790	0.0128	1.67
27900	Joplin, MO	0.8605	0.8951	0.0346	4.02
28020	Kalamazoo-Portage, MI	1.0704	1.0433	−0.0271	−2.53
28100	Kankakee-Bradley, IL	1.0083	1.0238	0.0155	1.54
28140	Kansas City, MO-KS	0.9495	0.9504	0.0009	0.09
28420	Kennewick-Richland-Pasco, WA	1.0343	1.0075	−0.0268	−2.59
28660	Killeen-Temple-Fort Hood, TX	0.8901	0.8249	−0.0652	−7.33
28700	Kingsport-Bristol, TN-VA	0.7985	0.7658	−0.0327	−4.10
28740	Kingston, NY	0.9367	0.9556	0.0189	2.02
28940	Knoxville, TN	0.8249	0.8036	−0.0213	−2.58
29020	Kokomo, IN	0.9669	0.9591	−0.0078	−0.81
29100	La Crosse, WI-MN	0.9426	0.9685	0.0259	2.75
29140	Lafayette, IN	0.8931	0.8869	−0.0062	−0.69
29180	Lafayette, LA	0.8289	0.8247	−0.0042	−0.51
29340	Lake Charles, LA	0.7914	0.7777	−0.0137	−1.73
29404	Lake County-Kenosha County, IL-WI	1.0570	1.0603	0.0033	0.31
29420	Lake Havasu City-Kingman, AZ	.....	0.9333	.....	.....
29460	Lakeland, FL	0.8879	0.8661	−0.0218	−2.46
29540	Lancaster, PA	0.9589	0.9252	−0.0337	−3.51
29620	Lansing-East Lansing, MI	1.0088	1.0119	0.0031	0.31
29700	Laredo, TX	0.7811	0.8093	0.0282	3.61
29740	Las Cruces, NM	0.9273	0.8676	−0.0597	−6.44
29820	Las Vegas-Paradise, NV	1.1430	1.1799	0.0369	3.23
29940	Lawrence, KS	0.8365	0.8227	−0.0138	−1.65
30020	Lawton, OK	0.8065	0.8025	−0.0040	−0.50
30140	Lebanon, PA	0.8679	0.8192	−0.0487	−5.61
30300	Lewiston, ID-WA	0.9853	0.9454	−0.0399	−4.05
30340	Lewiston-Auburn, ME	0.9126	0.9193	0.0067	0.73
30460	Lexington-Fayette, KY	0.9181	0.9191	0.0010	0.11
30620	Lima, OH	0.9042	0.9424	0.0382	4.22
30700	Lincoln, NE	1.0092	1.0051	−0.0041	−0.41
30780	Little Rock-North Little Rock, AR	0.8890	0.8863	−0.0027	−0.30
30860	Logan, UT-ID	0.9022	0.9183	0.0161	1.78
30980	Longview, TX	0.8788	0.8717	−0.0071	−0.81
31020	Longview, WA	1.0011	1.0827	0.0816	8.15
31084	Los Angeles-Long Beach-Santa Ana, CA	1.1760	1.1771	0.0011	0.09
31140	Louisville-Jefferson County, KY-IN	0.9118	0.9065	−0.0053	−0.58
31180	Lubbock, TX	0.8613	0.8680	0.0067	0.78
31340	Lynchburg, VA	0.8694	0.8732	0.0038	0.44
31420	Macon, GA	0.9519	0.9541	0.0022	0.23
31460	Madera, CA	0.8154	0.8069	−0.0085	−1.04
31540	Madison, WI	1.0840	1.0935	0.0095	0.88
31700	Manchester-Nashua, NH	1.0243	1.0273	0.0030	0.29
31900	Mansfield, OH	0.9271	0.9271	0.0000	0.00
32420	Mayagüez, PR	0.3848	0.3711	−0.0137	−3.56
32580	McAllen-Edinburg-Mission, TX	0.8773	0.9123	0.0350	3.99
32780	Medford, OR	1.0818	1.0318	−0.0500	−4.62
32820	Memphis, TN-MS-AR	0.9373	0.9250	−0.0123	−1.31
32900	Merced, CA	1.1471	1.2120	0.0649	5.66
33124	Miami-Miami Beach-Kendall, FL	0.9812	1.0002	0.0190	1.94
33140	Michigan City-La Porte, IN	0.9118	0.8914	−0.0204	−2.24
33260	Midland, TX	0.9786	1.0017	0.0231	2.36
33340	Milwaukee-Waukesha-West Allis, WI	1.0218	1.0214	−0.0004	−0.04
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.0946	1.1093	0.0147	1.34
33540	Missoula, MT	0.8928	0.8953	0.0025	0.28
33660	Mobile, AL	0.7913	0.8033	0.0120	1.52
33700	Modesto, CA	1.1729	1.1962	0.0233	1.99
33740	Monroe, LA	0.7997	0.7832	−0.0165	−2.06
33780	Monroe, MI	0.9707	0.9414	−0.0293	−3.02
33860	Montgomery, AL	0.8009	0.8088	0.0079	0.99
34060	Morgantown, WV	0.8423	0.8321	−0.0102	−1.21
34100	Morristown, TN	0.7933	0.7388	−0.0545	−6.87
34580	Mount Vernon-Anacortes, WA	1.0517	1.0529	0.0012	0.11
34620	Muncie, IN	0.8562	0.8214	−0.0348	−4.06
34740	Muskegon-Norton Shores, MI	0.9941	0.9836	−0.0105	−1.06
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.8810	0.8634	−0.0176	−2.00
34900	Napa, CA	1.3374	1.4476	0.1102	8.24
34940	Naples-Marco Island, FL	0.9941	0.9487	−0.0454	−4.57
34980	Nashville-Davidson-Murfreesboro, TN	0.9847	0.9689	−0.0158	−1.60

ADDENDUM C—COMPARISON OF RAW PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX VALUES USED AS INPUT VALUES TO DERIVE THE FY 2008 AND FY 2009 HOSPICE WAGE INDICES—Continued

[For illustrative purposes only]

		FY2008	FY2009	FY09–FY08	Percent chng
35004	Nassau-Suffolk, NY	1.2662	1.2640	−0.0022	−0.17
35084	Newark-Union, NJ-PA	1.1892	1.1862	−0.0030	−0.25
35300	New Haven-Milford, CT	1.1953	1.1871	−0.0082	−0.69
35380	New Orleans-Metairie-Kenner, LA	0.8831	0.8897	0.0066	0.75
35644	New York-White Plains-Wayne, NY-NJ	1.3177	1.3115	−0.0062	−0.47
35660	Niles-Benton Harbor, MI	0.8915	0.9141	0.0226	2.54
35980	Norwich-New London, CT	1.1932	1.1432	−0.0500	−4.19
36084	Oakland-Fremont-Hayward, CA	1.5819	1.5685	−0.0134	−0.85
36100	Ocala, FL	0.8867	0.8627	−0.0240	−2.71
36140	Ocean City, NJ	1.0472	1.0988	0.0516	4.93
36220	Odessa, TX	1.0073	1.0042	−0.0031	−0.31
36260	Ogden-Clearfield, UT	0.8995	0.9000	0.0005	0.06
36420	Oklahoma City, OK	0.8843	0.8815	−0.0028	−0.32
36500	Olympia, WA	1.1081	1.1512	0.0431	3.89
36540	Omaha-Council Bluffs, NE-IA	0.9450	0.9561	0.0111	1.17
36740	Orlando-Kissimmee, FL	0.9452	0.9226	−0.0226	−2.39
36780	Oshkosh-Neenah, WI	0.9315	0.9551	0.0236	2.53
36980	Owensboro, KY	0.8748	0.8652	−0.0096	−1.10
37100	Oxnard-Thousand Oaks-Ventura, CA	1.1546	1.1852	0.0306	2.65
37340	Palm Bay-Melbourne-Titusville, FL	0.9443	0.9325	−0.0118	−1.25
37380	Palm Coast, FL	.....	0.8945	.....	.....
37460	Panama City-Lynn Haven, FL	0.8027	0.8313	0.0286	3.56
37620	Parkersburg-Marietta-Vienna, WV-OH	0.7977	0.8105	0.0128	1.60
37700	Pascagoula, MS	0.8215	0.8647	0.0432	5.26
37764	Peabody, MA	.....	1.0650	.....	.....
37860	Pensacola-Ferry Pass-Brent, FL	0.8000	0.8281	0.0281	3.51
37900	Peoria, IL	0.8982	0.9299	0.0317	3.53
37964	Philadelphia, PA	1.0996	1.0925	−0.0071	−0.65
38060	Phoenix-Mesa-Scottsdale, AZ	1.0287	1.0264	−0.0023	−0.22
38220	Pine Bluff, AR	0.8383	0.7839	−0.0544	−6.49
38300	Pittsburgh, PA	0.8674	0.8525	−0.0149	−1.72
38340	Pittsfield, MA	1.0266	1.0091	−0.0175	−1.70
38540	Pocatello, ID	0.9400	0.9465	0.0065	0.69
38660	Ponce, PR	0.4842	0.4450	−0.0392	−8.10
38860	Portland-South Portland-Biddeford, ME	0.9908	1.0042	0.0134	1.35
38900	Portland-Vancouver-Beaverton, OR-WA	1.1416	1.1498	0.0082	0.72
38940	Port St. Lucie-Fort Pierce, FL	0.9833	1.0016	0.0183	1.86
39100	Poughkeepsie-Newburgh-Middletown, NY	1.0911	1.0982	0.0071	0.65
39140	Prescott, AZ	0.9836	1.0020	0.0184	1.87
39300	Providence-New Bedford-Fall River, RI-MA	1.0783	1.0574	−0.0209	−1.94
39340	Provo-Orem, UT	0.9537	0.9557	0.0020	0.21
39380	Pueblo, CO	0.8753	0.8851	0.0098	1.12
39460	Punta Gorda, FL	0.9405	0.9254	−0.0151	−1.61
39540	Racine, WI	0.9356	0.9498	0.0142	1.52
39580	Raleigh-Cary, NC	0.9864	0.9839	−0.0025	−0.25
39660	Rapid City, SD	0.8833	0.8811	−0.0022	−0.25
39740	Reading, PA	0.9622	0.9356	−0.0266	−2.76
39820	Redding, CA	1.3198	1.3541	0.0343	2.60
39900	Reno-Sparks, NV	1.1963	1.0715	−0.1248	−10.43
40060	Richmond, VA	0.9177	0.9425	0.0248	2.70
40140	Riverside-San Bernardino-Ontario, CA	1.0904	1.1100	0.0196	1.80
40220	Roanoke, VA	0.8647	0.8691	0.0044	0.51
40340	Rochester, MN	1.1408	1.0755	−0.0653	−5.72
40380	Rochester, NY	0.8994	0.8858	−0.0136	−1.51
40420	Rockford, IL	0.9989	0.9814	−0.0175	−1.75
40484	Rockingham County, NH	1.0159	1.0111	−0.0048	−0.47
40580	Rocky Mount, NC	0.8854	0.9001	0.0147	1.66
40660	Rome, GA	0.9193	0.9042	−0.0151	−1.64
40900	Sacramento—Arden-Arcade—Roseville, CA	1.3372	1.3505	0.0133	0.99
40980	Saginaw-Saginaw Township North, MI	0.8874	0.8812	−0.0062	−0.70
41060	St. Cloud, MN	1.0362	1.0549	0.0187	1.80
41100	St. George, UT	0.9265	0.9358	0.0093	1.00
41140	St. Joseph, MO-KS	1.0118	0.8762	−0.1356	−13.40
41180	St. Louis, MO-IL	0.9005	0.9024	0.0019	0.21
41420	Salem, OR	1.0438	1.0572	0.0134	1.28
41500	Salinas, CA	1.4337	1.4775	0.0438	3.06
41540	Salisbury, MD	0.8953	0.8994	0.0041	0.46
41620	Salt Lake City, UT	0.9402	0.9399	−0.0003	−0.03
41660	San Angelo, TX	0.8362	0.8579	0.0217	2.60

ADDENDUM C—COMPARISON OF RAW PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX VALUES USED AS INPUT VALUES TO DERIVE THE FY 2008 AND FY 2009 HOSPICE WAGE INDICES—Continued

[For illustrative purposes only]

		FY2008	FY2009	FY09–FY08	Percent chng
41700	San Antonio, TX	0.8844	0.8834	−0.0010	−0.11
41740	San Diego-Carlsbad-San Marcos, CA	1.1354	1.1492	0.0138	1.22
41780	Sandusky, OH	0.9302	0.8822	−0.0480	−5.16
41884	San Francisco-San Mateo-Redwood City, CA	1.5165	1.5195	0.0030	0.20
41900	San Germán-Cabo Rojo, PR	0.4885	0.4729	−0.0156	−3.19
41940	San Jose-Sunnyvale-Santa Clara, CA	1.5543	1.5735	0.0192	1.24
41980	San Juan-Caguas-Guaynabo, PR	0.4452	0.4528	0.0076	1.71
42020	San Luis Obispo-Paso Robles, CA	1.1598	1.2488	0.0890	7.67
42044	Santa Ana-Anaheim-Irvine, CA	1.1473	1.1766	0.0293	2.55
42060	Santa Barbara-Santa Maria, CA	1.1091	1.1714	0.0623	5.62
42100	Santa Cruz-Watsonville, CA	1.5457	1.6122	0.0665	4.30
42140	Santa Fe, NM	1.0824	1.0734	−0.0090	−0.83
42220	Santa Rosa-Petaluma, CA	1.4464	1.4696	0.0232	1.60
42260	Sarasota-Bradenton-Venice, FL	0.9868	0.9933	0.0065	0.66
42340	Savannah, GA	0.9351	0.9131	−0.0220	−2.35
42540	Scranton—Wilkes-Barre, PA	0.8347	0.8457	0.0110	1.32
42644	Seattle-Bellevue-Everett, WA	1.1434	1.1572	0.0138	1.21
42680	Sebastian-Vero Beach, FL	0.9573	0.9412	−0.0161	−1.68
43100	Sheboygan, WI	0.9026	0.8975	−0.0051	−0.57
43300	Sherman-Denison, TX	0.8502	0.8320	−0.0182	−2.14
43340	Shreveport-Bossier City, LA	0.8865	0.8476	−0.0389	−4.39
43580	Sioux City, IA-NE-SD	0.9200	0.9251	0.0051	0.55
43620	Sioux Falls, SD	0.9559	0.9563	0.0004	0.04
43780	South Bend-Mishawaka, IN-MI	0.9842	0.9617	−0.0225	−2.29
43900	Spartanburg, SC	0.9174	0.9422	0.0248	2.70
44060	Spokane, WA	1.0447	1.0455	0.0008	0.08
44100	Springfield, IL	0.8890	0.8944	0.0054	0.61
44140	Springfield, MA	1.0079	1.0366	0.0287	2.85
44180	Springfield, MO	0.8469	0.8695	0.0226	2.67
44220	Springfield, OH	0.8593	0.8694	0.0101	1.18
44300	State College, PA	0.8784	0.8768	−0.0016	−0.18
44700	Stockton, CA	1.1442	1.1855	0.0413	3.61
44940	Sumter, SC	0.8083	0.8599	0.0516	6.38
45060	Syracuse, NY	0.9691	0.9910	0.0219	2.26
45104	Tacoma, WA	1.0789	1.1055	0.0266	2.47
45220	Tallahassee, FL	0.8942	0.9025	0.0083	0.93
45300	Tampa-St. Petersburg-Clearwater, FL	0.9144	0.9020	−0.0124	−1.36
45460	Terre Haute, IN	0.8765	0.8805	0.0040	0.46
45500	Texarkana, TX-Texarkana, AR	0.8104	0.7770	−0.0334	−4.12
45780	Toledo, OH	0.9586	0.9431	−0.0155	−1.62
45820	Topeka, KS	0.8730	0.8538	−0.0192	−2.20
45940	Trenton-Ewing, NJ	1.0835	1.0699	−0.0136	−1.26
46060	Tucson, AZ	0.9202	0.9245	0.0043	0.47
46140	Tulsa, OK	0.8103	0.8340	0.0237	2.92
46220	Tuscaloosa, AL	0.8542	0.8303	−0.0239	−2.80
46340	Tyler, TX	0.8811	0.9114	0.0303	3.44
46540	Utica-Rome, NY	0.8396	0.8486	0.0090	1.07
46660	Valdosta, GA	0.8369	0.8098	−0.0271	−3.24
46700	Vallejo-Fairfield, CA	1.5137	1.4666	−0.0471	−3.11
47020	Victoria, TX	0.8560	0.8302	−0.0258	−3.01
47220	Vineland-Millville-Bridgeton, NJ	0.9832	1.0133	0.0301	3.06
47260	Virginia Beach-Norfolk-Newport News, VA	0.8790	0.8818	0.0028	0.32
47300	Visalia-Porterville, CA	0.9968	1.0091	0.0123	1.23
47380	Waco, TX	0.8633	0.8518	−0.0115	−1.33
47580	Warner Robins, GA	0.8380	0.9128	0.0748	8.93
47644	Warren-Troy-Farmington Hills, MI	1.0054	1.0001	−0.0053	−0.53
47894	Washington-Arlington-Alexandria, DC-VA	1.1054	1.0855	−0.0199	−1.80
47940	Waterloo-Cedar Falls, IA	0.8408	0.8519	0.0111	1.32
48140	Wausau, WI	0.9722	0.9679	−0.0043	−0.44
48260	Weirton-Steubenville, WV-OH	0.8063	0.7924	−0.0139	−1.72
48300	Wenatchee, WA	1.0346	1.1469	0.1123	10.85
48424	West Palm Beach-Boca Raton-Boynton, FL	0.9649	0.9728	0.0079	0.82
48540	Wheeling, WV-OH	0.7010	0.6961	−0.0049	−0.70
48620	Wichita, KS	0.9063	0.9062	−0.0001	−0.01
48660	Wichita Falls, TX	0.8311	0.7920	−0.0391	−4.70
48700	Williamsport, PA	0.8139	0.8043	−0.0096	−1.18
48864	Wilmington, DE-MD-NJ	1.0684	1.0824	0.0140	1.31
48900	Wilmington, NC	0.9835	0.9410	−0.0425	−4.32
49020	Winchester, VA-WV	1.0091	0.9913	−0.0178	−1.76

ADDENDUM C—COMPARISON OF RAW PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX VALUES USED AS INPUT VALUES TO DERIVE THE FY 2008 AND FY 2009 HOSPICE WAGE INDICES—Continued

[For illustrative purposes only]

		FY2008	FY2009	FY09–FY08	Percent chng
49180	Winston-Salem, NC	0.9276	0.9118	−0.0158	−1.70
49340	Worcester, MA	1.0722	1.1287	0.0565	5.27
49420	Yakima, WA	0.9847	1.0267	0.0420	4.27
49500	Yauco, PR	0.3854	0.3284	−0.0570	−14.79
49620	York-Hanover, PA	0.9397	0.9359	−0.0038	−0.40
49660	Youngstown-Warren-Boardman, OH-PA	0.8802	0.9002	0.0200	2.27
49700	Yuba City, CA	1.0730	1.0756	0.0026	0.24
49740	Yuma, AZ	0.9109	0.9488	0.0379	4.16

ADDENDUM D—COMPARISON OF RAW PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX VALUES USED AS INPUT VALUES TO DERIVE THE FY 2007 AND FY 2008 HOSPICE WAGE INDICES

[For illustrative purposes only]

		FY2007	FY2008	FY08–FY07	Percent chng
	Rural Area				
1	Alabama	0.7446	0.7591	0.0145	1.95
2	Alaska	1.1977	1.0661	−0.1316	−10.99
3	Arizona	0.8768	0.8908	0.0140	1.60
4	Arkansas	0.7466	0.7307	−0.0159	−2.13
5	California	1.1054	1.1454	0.0400	3.62
6	Colorado	0.9380	0.9325	−0.0055	−0.59
7	Connecticut	1.1730	1.1709	−0.0021	−0.18
8	Delaware	0.9579	0.9705	0.0126	1.32
10	Florida	0.8568	0.8594	0.0026	0.30
11	Georgia	0.7662	0.7593	−0.0069	−0.90
12	Hawaii	1.0551	1.0448	−0.0103	−0.98
13	Idaho	0.8037	0.8120	0.0083	1.03
14	Illinois	0.8271	0.8320	0.0049	0.59
15	Indiana	0.8624	0.8538	−0.0086	−1.00
16	Iowa	0.8509	0.8681	0.0172	2.02
17	Kansas	0.8035	0.7998	−0.0037	−0.46
18	Kentucky	0.7766	0.7768	0.0002	0.03
19	Louisiana	0.7411	0.7438	0.0027	0.36
20	Maine	0.8843	0.8443	−0.0400	−4.52
21	Maryland	0.9353	0.8926	−0.0427	−4.57
22	Massachusetts	1.0216	1.1661	0.1445	14.14
23	Michigan	0.8895	0.9062	0.0167	1.88
24	Minnesota	0.9132	0.9153	0.0021	0.23
25	Mississippi	0.7674	0.7738	0.0064	0.83
26	Missouri	0.7900	0.7927	0.0027	0.34
27	Montana	0.8762	0.8590	−0.0172	−1.96
28	Nebraska	0.8657	0.8677	0.0020	0.23
29	Nevada	0.9065	0.8944	−0.0121	−1.33
30	New Hampshire	1.0817	1.0853	0.0036	0.33
32	New Mexico	0.8635	0.8332	−0.0303	−3.51
33	New York	0.8154	0.8232	0.0078	0.96
34	North Carolina	0.8540	0.8588	0.0048	0.56
35	North Dakota	0.7261	0.7215	−0.0046	−0.63
36	Ohio	0.8826	0.8658	−0.0168	−1.90
37	Oklahoma	0.7581	0.7629	0.0048	0.63
38	Oregon	0.9826	0.9753	−0.0073	−0.74
39	Pennsylvania	0.8291	0.8320	0.0029	0.35
40	Puerto Rico	0.4047	0.4047	0.0000	0.00
42	South Carolina	0.8638	0.8566	−0.0072	−0.83
43	South Dakota	0.8560	0.8480	−0.0080	−0.93
44	Tennessee	0.7895	0.7827	−0.0068	−0.86
45	Texas	0.8003	0.7965	−0.0038	−0.47
46	Utah	0.8118	0.8140	0.0022	0.27
47	Vermont	0.9830	0.9744	−0.0086	−0.87
48	Virgin Islands	0.7615	0.8467	0.0852	11.19
49	Virginia	0.8013	0.7940	−0.0073	−0.91
50	Washington	1.0510	1.0263	−0.0247	−2.35
51	West Virginia	0.7717	0.7607	−0.0110	−1.43
52	Wisconsin	0.9509	0.9553	0.0044	0.46

ADDENDUM D—COMPARISON OF RAW PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX VALUES USED AS INPUT VALUES TO DERIVE THE FY 2007 AND FY 2008 HOSPICE WAGE INDICES—Continued

[For illustrative purposes only]

		FY2007	FY2008	FY08–FY07	Percent chng
53	Wyoming	0.9257	0.9295	0.0038	0.41
65	Guam	0.9611	0.9611	0.0000	0.00
CBSA	**Urban Area**				
10180	Abilene, TX	0.7896	0.8000	0.0104	1.32
10380	Aguadilla-Isabela-San Sebastián, PR	0.4738	0.3915	−0.0823	−17.37
10420	Akron, OH	0.8982	0.8654	−0.0328	−3.65
10500	Albany, GA	0.8628	0.8991	0.0363	4.21
10580	Albany-Schenectady-Troy, NY	0.8589	0.8720	0.0131	1.53
10740	Albuquerque, NM	0.9684	0.9458	−0.0226	−2.33
10780	Alexandria, LA	0.8033	0.8006	−0.0027	−0.34
10900	Allentown-Bethlehem-Easton, PA-NJ	0.9818	0.9947	0.0129	1.31
11020	Altoona, PA	0.8944	0.8812	−0.0132	−1.48
11100	Amarillo, TX	0.9156	0.9169	0.0013	0.14
11180	Ames, IA	0.9536	0.9760	0.0224	2.35
11260	Anchorage, AK	1.1895	1.2023	0.0128	1.08
11300	Anderson, IN	0.8586	0.8681	0.0095	1.11
11340	Anderson, SC	0.8997	0.9017	0.0020	0.22
11460	Ann Arbor, MI	1.0859	1.0826	−0.0033	−0.30
11500	Anniston-Oxford, AL	0.7682	0.7770	0.0088	1.15
11540	Appleton, WI	0.9288	0.9455	0.0167	1.80
11700	Asheville, NC	0.9285	0.9216	−0.0069	−0.74
12020	Athens-Clarke County, GA	0.9855	0.9856	0.0001	0.01
12060	Atlanta-Sandy Springs-Marietta, GA	0.9793	0.9762	−0.0031	−0.32
12100	Atlantic City, NJ	1.1615	1.1831	0.0216	1.86
12220	Auburn-Opelika, AL	0.8100	0.8096	−0.0004	−0.05
12260	Augusta-Richmond County, GA-SC	0.9748	0.9667	−0.0081	−0.83
12420	Austin-Round Rock, TX	0.9437	0.9344	−0.0093	−0.99
12540	Bakersfield, CA	1.0470	1.0725	0.0255	2.44
12580	Baltimore-Towson, MD	0.9897	1.0088	0.0191	1.93
12620	Bangor, ME	0.9993	0.9711	−0.0282	−2.82
12700	Barnstable Town, MA	1.2600	1.2539	−0.0061	−0.48
12940	Baton Rouge, LA	0.8593	0.8084	−0.0509	−5.92
12980	Battle Creek, MI	0.9508	0.9762	0.0254	2.67
13020	Bay City, MI	0.9343	0.9251	−0.0092	−0.98
13140	Beaumont-Port Arthur, TX	0.8412	0.8595	0.0183	2.18
13380	Bellingham, WA	1.1731	1.1104	−0.0627	−5.34
13460	Bend, OR	1.0786	1.0743	−0.0043	−0.40
13644	Bethesda-Gaithersburg-Frederick, MD	1.1483	1.0903	−0.0580	−5.05
13740	Billings, MT	0.8834	0.8712	−0.0122	−1.38
13780	Binghamton, NY	0.8562	0.8786	0.0224	2.62
13820	Birmingham-Hoover, AL	0.8959	0.8894	−0.0065	−0.73
13900	Bismarck, ND	0.7574	0.7240	−0.0334	−4.41
13980	Blacksburg-Christiansburg-Radford, VA	0.7954	0.8213	0.0259	3.26
14020	Bloomington, IN	0.8447	0.8533	0.0086	1.02
14060	Bloomington-Normal, IL	0.9075	0.8944	−0.0131	−1.44
14260	Boise City-Nampa, ID	0.9052	0.9401	0.0349	3.86
14484	Boston-Quincy, MA	1.1558	1.1679	0.0121	1.05
14500	Boulder, CO	0.9734	1.0350	0.0616	6.33
14540	Bowling Green, KY	0.8211	0.8148	−0.0063	−0.77
14740	Bremerton-Silverdale, WA	1.0675	1.0913	0.0238	2.23
14860	Bridgeport-Stamford-Norwalk, CT	1.2592	1.2659	0.0067	0.53
15180	Brownsville-Harlingen, TX	0.9804	0.9430	−0.0374	−3.81
15260	Brunswick, GA	0.9311	1.0164	0.0853	9.16
15380	Buffalo-Niagara Falls, NY	0.9511	0.9424	−0.0087	−0.91
15500	Burlington, NC	0.8905	0.8674	−0.0231	−2.59
15540	Burlington-South Burlington, VT	0.9410	0.9474	0.0064	0.68
15764	Cambridge-Newton-Framingham, MA	1.1172	1.0970	−0.0202	−1.81
15804	Camden, NJ	1.0517	1.0392	−0.0125	−1.19
15940	Canton-Massillon, OH	0.8935	0.9031	0.0096	1.07
15980	Cape Coral-Fort Myers, FL	0.9356	0.9342	−0.0014	−0.15
16180	Carson City, NV	1.0234	1.0025	−0.0209	−2.04
16220	Casper, WY	0.9026	0.9145	0.0119	1.32
16300	Cedar Rapids, IA	0.8825	0.8888	0.0063	0.71
16580	Champaign-Urbana, IL	0.9594	0.9644	0.0050	0.52
16620	Charleston, WV	0.8445	0.8542	0.0097	1.15
16700	Charleston-North Charleston, SC	0.9245	0.9145	−0.0100	−1.08
16740	Charlotte-Gastonia-Concord, NC-SC	0.9750	0.9554	−0.0196	−2.01

ADDENDUM D—COMPARISON OF RAW PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX VALUES USED AS INPUT VALUES TO DERIVE THE FY 2007 AND FY 2008 HOSPICE WAGE INDICES—Continued

[For illustrative purposes only]

		FY2007	FY2008	FY08–FY07	Percent chng
16820	Charlottesville, VA	1.0187	1.0125	−0.0062	−0.61
16860	Chattanooga, TN-GA	0.9088	0.8948	−0.0140	−1.54
16940	Cheyenne, WY	0.8775	0.9060	0.0285	3.25
16974	Chicago-Naperville-Joliet, IL	1.0790	1.0751	−0.0039	−0.36
17020	Chico, CA	1.0511	1.1053	0.0542	5.16
17140	Cincinnati-Middletown, OH-KY-IN	0.9615	0.9601	−0.0014	−0.15
17300	Clarksville, TN-KY	0.8284	0.8436	0.0152	1.83
17420	Cleveland, TN	0.8139	0.8109	−0.0030	−0.37
17460	Cleveland-Elyria-Mentor, OH	0.9213	0.9400	0.0187	2.03
17660	Coeur d'Alene, ID	0.9647	0.9344	−0.0303	−3.14
17780	College Station-Bryan, TX	0.8900	0.9045	0.0145	1.63
17820	Colorado Springs, CO	0.9468	0.9701	0.0233	2.46
17860	Columbia, MO	0.8345	0.8542	0.0197	2.36
17900	Columbia, SC	0.9057	0.8933	−0.0124	−1.37
17980	Columbus, GA-AL	0.8560	0.8239	−0.0321	−3.75
18020	Columbus, IN	0.9588	0.9318	−0.0270	−2.82
18140	Columbus, OH	0.9860	1.0107	0.0247	2.51
18580	Corpus Christi, TX	0.8550	0.8564	0.0014	0.16
18700	Corvallis, OR	1.0729	1.1546	0.0817	7.61
19060	Cumberland, MD-WV	0.9317	0.8446	−0.0871	−9.35
19124	Dallas-Plano-Irving, TX	1.0228	1.0075	−0.0153	−1.50
19140	Dalton, GA	0.9079	0.9093	0.0014	0.15
19180	Danville, IL	0.9028	0.9266	0.0238	2.64
19260	Danville, VA	0.8489	0.8451	−0.0038	−0.45
19340	Davenport-Moline-Rock Island, IA-IL	0.8724	0.8846	0.0122	1.40
19380	Dayton, OH	0.9064	0.9037	−0.0027	−0.30
19460	Decatur, AL	0.8469	0.8159	−0.0310	−3.66
19500	Decatur, IL	0.8067	0.8172	0.0105	1.30
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.9299	0.9263	−0.0036	−0.39
19740	Denver-Aurora, CO	1.0723	1.0930	0.0207	1.93
19780	Des Moines-West Des Moines, IA	0.9669	0.9214	−0.0455	−4.71
19804	Detroit-Livonia-Dearborn, MI	1.0424	1.0281	−0.0143	−1.37
20020	Dothan, AL	0.7721	0.7381	−0.0340	−4.40
20100	Dover, DE	0.9776	0.9847	0.0071	0.73
20220	Dubuque, IA	0.9024	0.9133	0.0109	1.21
20260	Duluth, MN-WI	1.0213	1.0042	−0.0171	−1.67
20500	Durham, NC	1.0244	0.9826	−0.0418	−4.08
20740	Eau Claire, WI	0.9201	0.9630	0.0429	4.66
20764	Edison, NJ	1.1249	1.1190	−0.0059	−0.52
20940	El Centro, CA	0.8906	0.9076	0.0170	1.91
21060	Elizabethtown, KY	0.8802	0.8697	−0.0105	−1.19
21140	Elkhart-Goshen, IN	0.9627	0.9426	−0.0201	−2.09
21300	Elmira, NY	0.8250	0.8240	−0.0010	−0.12
21340	El Paso, TX	0.8977	0.9053	0.0076	0.85
21500	Erie, PA	0.8737	0.8827	0.0090	1.03
21604	Essex County, MA	1.0538	1.0418	−0.0120	−1.14
21660	Eugene-Springfield, OR	1.0818	1.0876	0.0058	0.54
21780	Evansville, IN-KY	0.8713	0.9071	0.0358	4.11
21820	Fairbanks, AK	1.1408	1.1059	−0.0349	−3.06
21940	Fajardo, PR	0.4153	0.4036	−0.0117	−2.82
22020	Fargo, ND-MN	0.8486	0.8250	−0.0236	−2.78
22140	Farmington, NM	0.8509	0.8589	0.0080	0.94
22180	Fayetteville, NC	0.9416	0.8945	−0.0471	−5.00
22220	Fayetteville-Springdale-Rogers, AR-MO	0.8661	0.8865	0.0204	2.36
22380	Flagstaff, AZ	1.2092	1.1601	−0.0491	−4.06
22420	Flint, MI	1.0655	1.0969	0.0314	2.95
22500	Florence, SC	0.8947	0.8388	−0.0559	−6.25
22520	Florence-Muscle Shoals, AL	0.8272	0.7843	−0.0429	−5.19
22540	Fond du Lac, WI	0.9640	1.0063	0.0423	4.39
22660	Fort Collins-Loveland, CO	1.0122	0.9544	−0.0578	−5.71
22744	Ft Lauderdale-Pompano Beach-Deerfield, FL	1.0432	1.0133	−0.0299	−2.87
22900	Fort Smith, AR-OK	0.8230	0.7731	−0.0499	−6.06
23020	Fort Walton Beach-Crestview-Destin, FL	0.8872	0.8643	−0.0229	−2.58
23060	Fort Wayne, IN	0.9793	0.9517	−0.0276	−2.82
23104	Fort Worth-Arlington, TX	0.9486	0.9569	0.0083	0.87
23420	Fresno, CA	1.0538	1.0943	0.0405	3.84
23460	Gadsden, AL	0.7938	0.8066	0.0128	1.61
23540	Gainesville, FL	0.9388	0.9277	−0.0111	−1.18
23580	Gainesville, GA	0.8874	0.8958	0.0084	0.95

ADDENDUM D—COMPARISON OF RAW PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX VALUES USED AS INPUT VALUES TO DERIVE THE FY 2007 AND FY 2008 HOSPICE WAGE INDICES—Continued

[For illustrative purposes only]

		FY2007	FY2008	FY08–FY07	Percent chng
23844	Gary, IN	0.9395	0.9334	−0.0061	−0.65
24020	Glens Falls, NY	0.8559	0.8324	−0.0235	−2.75
24140	Goldsboro, NC	0.8775	0.9171	0.0396	4.51
24220	Grand Forks, ND-MN	0.7901	0.7949	0.0048	0.61
24300	Grand Junction, CO	0.9550	0.9668	0.0118	1.24
24340	Grand Rapids-Wyoming, MI	0.9390	0.9455	0.0065	0.69
24500	Great Falls, MT	0.9052	0.8598	−0.0454	−5.02
24540	Greeley, CO	0.9570	0.9602	0.0032	0.33
24580	Green Bay, WI	0.9483	0.9787	0.0304	3.21
24660	Greensboro-High Point, NC	0.9104	0.8866	−0.0238	−2.61
24780	Greenville, NC	0.9425	0.9432	0.0007	0.07
24860	Greenville, SC	1.0027	0.9804	−0.0223	−2.22
25020	Guayama, PR	0.3181	0.3235	0.0054	1.70
25060	Gulfport-Biloxi, MS	0.8929	0.8915	−0.0014	−0.16
25180	Hagerstown-Martinsburg, MD-WV	0.9489	0.9038	−0.0451	−4.75
25260	Hanford-Corcoran, CA	1.0036	1.0282	0.0246	2.45
25420	Harrisburg-Carlisle, PA	0.9313	0.9402	0.0089	0.96
25500	Harrisonburg, VA	0.9088	0.9073	−0.0015	−0.17
25540	Hartford-West Hartford-East Hartford, CT	1.1073	1.0894	−0.0179	−1.62
25620	Hattiesburg, MS	0.7601	0.7430	−0.0171	−2.25
25860	Hickory-Lenoir-Morganton, NC	0.8921	0.9010	0.0089	1.00
25980	Hinesville-Fort Stewart, GA	0.9198	0.9178	−0.0020	−0.22
26100	Holland-Grand Haven, MI	0.9055	0.9163	0.0108	1.19
26180	Honolulu, HI	1.1214	1.1096	−0.0118	−1.05
26300	Hot Springs, AR	0.9005	0.8782	−0.0223	−2.48
26380	Houma-Bayou Cane-Thibodaux, LA	0.7894	0.8082	0.0188	2.38
26420	Houston-Sugar Land-Baytown, TX	0.9996	1.0008	0.0012	0.12
26580	Huntington-Ashland, WV-KY-OH	0.9477	0.8997	−0.0480	−5.06
26620	Huntsville, AL	0.9146	0.9007	−0.0139	−1.52
26820	Idaho Falls, ID	0.9420	0.9088	−0.0332	−3.52
26900	Indianapolis-Carmel, IN	0.9920	0.9895	−0.0025	−0.25
26980	Iowa City, IA	0.9747	0.9714	−0.0033	−0.34
27060	Ithaca, NY	0.9793	0.9928	0.0135	1.38
27100	Jackson, MI	0.9304	0.9560	0.0256	2.75
27140	Jackson, MS	0.8311	0.8271	−0.0040	−0.48
27180	Jackson, TN	0.8964	0.8853	−0.0111	−1.24
27260	Jacksonville, FL	0.9290	0.9165	−0.0125	−1.35
27340	Jacksonville, NC	0.8236	0.8231	−0.0005	−0.06
27500	Janesville, WI	0.9538	0.9655	0.0117	1.23
27620	Jefferson City, MO	0.8387	0.8332	−0.0055	−0.66
27740	Johnson City, TN	0.7937	0.8043	0.0106	1.34
27780	Johnstown, PA	0.8354	0.8620	0.0266	3.18
27860	Jonesboro, AR	0.7911	0.7662	−0.0249	−3.15
27900	Joplin, MO	0.8582	0.8605	0.0023	0.27
28020	Kalamazoo-Portage, MI	1.0381	1.0704	0.0323	3.11
28100	Kankakee-Bradley, IL	1.0721	1.0083	−0.0638	−5.95
28140	Kansas City, MO-KS	0.9476	0.9495	0.0019	0.20
28420	Kennewick-Richland-Pasco, WA	1.0619	1.0343	−0.0276	−2.60
28660	Killeen-Temple-Fort Hood, TX	0.8526	0.8901	0.0375	4.40
28700	Kingsport-Bristol-Bristol, TN-VA	0.8054	0.7985	−0.0069	−0.86
28740	Kingston, NY	0.9255	0.9367	0.0112	1.21
28940	Knoxville, TN	0.8441	0.8249	−0.0192	−2.27
29020	Kokomo, IN	0.9508	0.9669	0.0161	1.69
29100	La Crosse, WI-MN	0.9564	0.9426	−0.0138	−1.44
29140	Lafayette, IN	0.8736	0.8931	0.0195	2.23
29180	Lafayette, LA	0.8428	0.8289	−0.0139	−1.65
29340	Lake Charles, LA	0.7833	0.7914	0.0081	1.03
29404	Lake County-Kenosha County, IL-WI	1.0429	1.0570	0.0141	1.35
29460	Lakeland, FL	0.8912	0.8879	−0.0033	−0.37
29540	Lancaster, PA	0.9694	0.9589	−0.0105	−1.08
29620	Lansing-East Lansing, MI	0.9794	1.0088	0.0294	3.00
29700	Laredo, TX	0.8068	0.7811	−0.0257	−3.19
29740	Las Cruces, NM	0.8467	0.9273	0.0806	9.52
29820	Las Vegas-Paradise, NV	1.1437	1.1430	−0.0007	−0.06
29940	Lawrence, KS	0.8537	0.8365	−0.0172	−2.01
30020	Lawton, OK	0.7872	0.8065	0.0193	2.45
30140	Lebanon, PA	0.8459	0.8679	0.0220	2.60
30300	Lewiston, ID-WA	0.9886	0.9853	−0.0033	−0.33
30340	Lewiston-Auburn, ME	0.9331	0.9126	−0.0205	−2.20

ADDENDUM D—COMPARISON OF RAW PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX VALUES USED AS INPUT VALUES TO DERIVE THE FY 2007 AND FY 2008 HOSPICE WAGE INDICES—Continued

[For illustrative purposes only]

		FY2007	FY2008	FY08–FY07	Percent chng
30460	Lexington-Fayette, KY	0.9075	0.9181	0.0106	1.17
30620	Lima, OH	0.9225	0.9042	−0.0183	−1.98
30700	Lincoln, NE	1.0214	1.0092	−0.0122	−1.19
30780	Little Rock-North Little Rock, AR	0.8747	0.8890	0.0143	1.63
30860	Logan, UT-ID	0.9164	0.9022	−0.0142	−1.55
30980	Longview, TX	0.8730	0.8788	0.0058	0.66
31020	Longview, WA	0.9579	1.0011	0.0432	4.51
31084	Los Angeles-Long Beach-Santa Ana, CA	1.1783	1.1760	−0.0023	−0.20
31140	Louisville-Jefferson County, KY-IN	0.9251	0.9118	−0.0133	−1.44
31180	Lubbock, TX	0.8783	0.8613	−0.0170	−1.94
31340	Lynchburg, VA	0.8691	0.8694	0.0003	0.03
31420	Macon, GA	0.9443	0.9519	0.0076	0.80
31460	Madera, CA	0.8713	0.8154	−0.0559	−6.42
31540	Madison, WI	1.0659	1.0840	0.0181	1.70
31700	Manchester-Nashua, NH	1.0354	1.0243	−0.0111	−1.07
31900	Mansfield, OH	0.9891	0.9271	−0.0620	−6.27
32420	Mayagüez, PR	0.4020	0.3848	−0.0172	−4.28
32580	McAllen-Edinburg-Mission, TX	0.8934	0.8773	−0.0161	−1.80
32780	Medford, OR	1.0225	1.0818	0.0593	5.80
32820	Memphis, TN-MS-AR	0.9397	0.9373	−0.0024	−0.26
32900	Merced, CA	1.1109	1.1471	0.0362	3.26
33124	Miami-Miami Beach-Kendall, FL	0.9750	0.9812	0.0062	0.64
33140	Michigan City-La Porte, IN	0.9399	0.9118	−0.0281	−2.99
33260	Midland, TX	0.9514	0.9786	0.0272	2.86
33340	Milwaukee-Waukesha-West Allis, WI	1.0146	1.0218	0.0072	0.71
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.1075	1.0946	−0.0129	−1.16
33540	Missoula, MT	0.9473	0.8928	−0.0545	−5.75
33660	Mobile, AL	0.7891	0.7913	0.0022	0.28
33700	Modesto, CA	1.1885	1.1729	−0.0156	−1.31
33740	Monroe, LA	0.8031	0.7997	−0.0034	−0.42
33780	Monroe, MI	0.9468	0.9707	0.0239	2.52
33860	Montgomery, AL	0.8618	0.8009	−0.0609	−7.07
34060	Morgantown, WV	0.8420	0.8423	0.0003	0.04
34100	Morristown, TN	0.7961	0.7933	−0.0028	−0.35
34580	Mount Vernon-Anacortes, WA	1.0454	1.0517	0.0063	0.60
34620	Muncie, IN	0.8930	0.8562	−0.0368	−4.12
34740	Muskegon-Norton Shores, MI	0.9664	0.9941	0.0277	2.87
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.8934	0.8810	−0.0124	−1.39
34900	Napa, CA	1.2643	1.3374	0.0731	5.78
34940	Naples-Marco Island, FL	1.0139	0.9941	−0.0198	−1.95
34980	Nashville-Davidson—Murfreesboro, TN	0.9790	0.9847	0.0057	0.58
35004	Nassau-Suffolk, NY	1.2719	1.2662	−0.0057	−0.45
35084	Newark-Union, NJ-PA	1.1883	1.1892	0.0009	0.08
35300	New Haven-Milford, CT	1.1887	1.1953	0.0066	0.56
35380	New Orleans-Metairie-Kenner, LA	0.8995	0.8831	−0.0164	−1.82
35644	New York-White Plains-Wayne, NY-NJ	1.3188	1.3177	−0.0011	−0.08
35660	Niles-Benton Harbor, MI	0.8879	0.8915	0.0036	0.41
35980	Norwich-New London, CT	1.1345	1.1932	0.0587	5.17
36084	Oakland-Fremont-Hayward, CA	1.5346	1.5819	0.0473	3.08
36100	Ocala, FL	0.8925	0.8867	−0.0058	−0.65
36140	Ocean City, NJ	1.1011	1.0472	−0.0539	−4.90
36220	Odessa, TX	0.9884	1.0073	0.0189	1.91
36260	Ogden-Clearfield, UT	0.9029	0.8995	−0.0034	−0.38
36420	Oklahoma City, OK	0.9031	0.8843	−0.0188	−2.08
36500	Olympia, WA	1.0927	1.1081	0.0154	1.41
36540	Omaha-Council Bluffs, NE-IA	0.9560	0.9450	−0.0110	−1.15
36740	Orlando-Kissimmee, FL	0.9464	0.9452	−0.0012	−0.13
36780	Oshkosh-Neenah, WI	0.9183	0.9315	0.0132	1.44
36980	Owensboro, KY	0.8780	0.8748	−0.0032	−0.36
37100	Oxnard-Thousand Oaks-Ventura, CA	1.1622	1.1546	−0.0076	−0.65
37340	Palm Bay-Melbourne-Titusville, FL	0.9839	0.9443	−0.0396	−4.02
37460	Panama City-Lynn Haven, FL	0.8005	0.8027	0.0022	0.27
37620	Parkersburg-Marietta-Vienna, WV-OH	0.8270	0.7977	−0.0293	−3.54
37700	Pascagoula, MS	0.8156	0.8215	0.0059	0.72
37860	Pensacola-Ferry Pass-Brent, FL	0.8096	0.8000	−0.0096	−1.19
37900	Peoria, IL	0.8870	0.8982	0.0112	1.26
37964	Philadelphia, PA	1.1038	1.0996	−0.0042	−0.38
38060	Phoenix-Mesa-Scottsdale, AZ	1.0127	1.0287	0.0160	1.58
38220	Pine Bluff, AR	0.8680	0.8383	−0.0297	−3.42

ADDENDUM D—COMPARISON OF RAW PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX VALUES USED AS INPUT VALUES TO DERIVE THE FY 2007 AND FY 2008 HOSPICE WAGE INDICES—Continued

[For illustrative purposes only]

		FY2007	FY2008	FY08–FY07	Percent chng
38300	Pittsburgh, PA	0.8845	0.8674	−0.0171	−1.93
38340	Pittsfield, MA	1.0181	1.0266	0.0085	0.83
38540	Pocatello, ID	0.9351	0.9400	0.0049	0.52
38660	Ponce, PR	0.4939	0.4842	−0.0097	−1.96
38860	Portland-South Portland-Biddeford, ME	1.0382	0.9908	−0.0474	−4.57
38900	Portland-Vancouver-Beaverton, OR-WA	1.1266	1.1416	0.0150	1.33
38940	Port St. Lucie-Fort Pierce, FL	1.0123	0.9833	−0.0290	−2.86
39100	Poughkeepsie-Newburgh-Middletown, NY	1.0891	1.0911	0.0020	0.18
39140	Prescott, AZ	0.9869	0.9836	−0.0033	−0.33
39300	Providence-New Bedford-Fall River, RI-MA	1.0966	1.0783	−0.0183	−1.67
39340	Provo-Orem, UT	0.9500	0.9537	0.0037	0.39
39380	Pueblo, CO	0.8623	0.8753	0.0130	1.51
39460	Punta Gorda, FL	0.9255	0.9405	0.0150	1.62
39540	Racine, WI	0.8997	0.9356	0.0359	3.99
39580	Raleigh-Cary, NC	0.9691	0.9864	0.0173	1.79
39660	Rapid City, SD	0.8987	0.8833	−0.0154	−1.71
39740	Reading, PA	0.9686	0.9622	−0.0064	−0.66
39820	Redding, CA	1.2203	1.3198	0.0995	8.15
39900	Reno-Sparks, NV	1.0982	1.1963	0.0981	8.93
40060	Richmond, VA	0.9328	0.9177	−0.0151	−1.62
40140	Riverside-San Bernardino-Ontario, CA	1.1027	1.0904	−0.0123	−1.12
40220	Roanoke, VA	0.8374	0.8647	0.0273	3.26
40340	Rochester, MN	1.1131	1.1408	0.0277	2.49
40380	Rochester, NY	0.9121	0.8994	−0.0127	−1.39
40420	Rockford, IL	0.9984	0.9989	0.0005	0.05
40484	Rockingham County, NH	1.0374	1.0159	−0.0215	−2.07
40580	Rocky Mount, NC	0.8915	0.8854	−0.0061	−0.68
40660	Rome, GA	0.9414	0.9193	−0.0221	−2.35
40900	Sacramento—Arden-Arcade—Roseville, CA	1.2969	1.3372	0.0403	3.11
40980	Saginaw-Saginaw Township North, MI	0.9088	0.8874	−0.0214	−2.35
41060	St. Cloud, MN	0.9965	1.0362	0.0397	3.98
41100	St. George, UT	0.9392	0.9265	−0.0127	−1.35
41140	St. Joseph, MO-KS	0.9519	1.0118	0.0599	6.29
41180	St. Louis, MO-IL	0.8954	0.9005	0.0051	0.57
41420	Salem, OR	1.0442	1.0438	−0.0004	−0.04
41500	Salinas, CA	1.4128	1.4337	0.0209	1.48
41540	Salisbury, MD	0.9064	0.8953	−0.0111	−1.22
41620	Salt Lake City, UT	0.9421	0.9402	−0.0019	−0.20
41660	San Angelo, TX	0.8271	0.8362	0.0091	1.10
41700	San Antonio, TX	0.8980	0.8844	−0.0136	−1.51
41740	San Diego-Carlsbad-San Marcos, CA	1.1413	1.1354	−0.0059	−0.52
41780	Sandusky, OH	0.9019	0.9302	0.0283	3.14
41884	San Francisco-San Mateo-Redwood City,CA	1.4994	1.5165	0.0171	1.14
41900	San Germán-Cabo Rojo, PR	0.4650	0.4885	0.0235	5.05
41940	San Jose-Sunnyvale-Santa Clara, CA	1.5099	1.5543	0.0444	2.94
41980	San Juan-Caguas-Guaynabo, PR	0.4621	0.4452	−0.0169	−3.66
42020	San Luis Obispo-Paso Robles, CA	1.1349	1.1598	0.0249	2.19
42044	Santa Ana-Anaheim-Irvine, CA	1.1559	1.1473	−0.0086	−0.74
42060	Santa Barbara-Santa Maria, CA	1.1694	1.1091	−0.0603	−5.16
42100	Santa Cruz-Watsonville, CA	1.5166	1.5457	0.0291	1.92
42140	Santa Fe, NM	1.0920	1.0824	−0.0096	−0.88
42220	Santa Rosa-Petaluma, CA	1.3493	1.4464	0.0971	7.20
42260	Sarasota-Bradenton-Venice, FL	0.9639	0.9868	0.0229	2.38
42340	Savannah, GA	0.9461	0.9351	−0.0110	−1.16
42540	Scranton—Wilkes-Barre, PA	0.8540	0.8347	−0.0193	−2.26
42644	Seattle-Bellevue-Everett, WA	1.1577	1.1434	−0.0143	−1.24
42680	Sebastian-Vero Beach, FL	.....	0.9573	0.9573	.....
43100	Sheboygan, WI	0.8911	0.9026	0.0115	1.29
43300	Sherman-Denison, TX	0.9507	0.8502	−0.1005	−10.57
43340	Shreveport-Bossier City, LA	0.8760	0.8865	0.0105	1.20
43580	Sioux City, IA-NE-SD	0.9381	0.9200	−0.0181	−1.93
43620	Sioux Falls, SD	0.9635	0.9559	−0.0076	−0.79
43780	South Bend-Mishawaka, IN-MI	0.9788	0.9842	0.0054	0.55
43900	Spartanburg, SC	0.9172	0.9174	0.0002	0.02
44060	Spokane, WA	1.0905	1.0447	−0.0458	−4.20
44100	Springfield, IL	0.8792	0.8890	0.0098	1.11
44140	Springfield, MA	1.0248	1.0079	−0.0169	−1.65
44180	Springfield, MO	0.8237	0.8469	0.0232	2.82
44220	Springfield, OH	0.8396	0.8593	0.0197	2.35

ADDENDUM D—COMPARISON OF RAW PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX VALUES USED AS INPUT VALUES TO DERIVE THE FY 2007 AND FY 2008 HOSPICE WAGE INDICES—Continued

[For illustrative purposes only]

		FY2007	FY2008	FY08–FY07	Percent chng
44300	State College, PA	0.8356	0.8784	0.0428	5.12
44700	Stockton, CA	1.1307	1.1442	0.0135	1.19
44940	Sumter, SC	0.8377	0.8083	−0.0294	−3.51
45060	Syracuse, NY	0.9574	0.9691	0.0117	1.22
45104	Tacoma, WA	1.0742	1.0789	0.0047	0.44
45220	Tallahassee, FL	0.8688	0.8942	0.0254	2.92
45300	Tampa-St. Petersburg-Clearwater, FL	0.9233	0.9144	−0.0089	−0.96
45460	Terre Haute, IN	0.8304	0.8765	0.0461	5.55
45500	Texarkana, TX-Texarkana, AR	0.8283	0.8104	−0.0179	−2.16
45780	Toledo, OH	0.9574	0.9586	0.0012	0.13
45820	Topeka, KS	0.8920	0.8730	−0.0190	−2.13
45940	Trenton-Ewing, NJ	1.0834	1.0835	0.0001	0.01
46060	Tucson, AZ	0.9007	0.9202	0.0195	2.16
46140	Tulsa, OK	0.8543	0.8103	−0.0440	−5.15
46220	Tuscaloosa, AL	0.8645	0.8542	−0.0103	−1.19
46340	Tyler, TX	0.9168	0.8811	−0.0357	−3.89
46540	Utica-Rome, NY	0.8358	0.8396	0.0038	0.45
46660	Valdosta, GA	0.8866	0.8369	−0.0497	−5.61
46700	Vallejo-Fairfield, CA	1.4936	1.5137	0.0201	1.35
46940	Vero Beach, FL	0.9434	.....	−0.9434	.....
47020	Victoria, TX	0.8160	0.8560	0.0400	4.90
47220	Vineland-Millville-Bridgeton, NJ	0.9827	0.9832	0.0005	0.05
47260	Virginia Beach-Norfolk-Newport News, VA	0.8799	0.8790	−0.0009	−0.10
47300	Visalia-Porterville, CA	1.0123	0.9968	−0.0155	−1.53
47380	Waco, TX	0.8518	0.8633	0.0115	1.35
47580	Warner Robins, GA	0.8645	0.8380	−0.0265	−3.07
47644	Warren-Troy-Farmington Hills, MI	0.9871	1.0054	0.0183	1.85
47894	Washington-Arlington-Alexandria, DC-VA	1.0926	1.1054	0.0128	1.17
47940	Waterloo-Cedar Falls, IA	0.8557	0.8408	−0.0149	−1.74
48140	Wausau, WI	0.9590	0.9722	0.0132	1.38
48260	Weirton-Steubenville, WV-OH	0.7819	0.8063	0.0244	3.12
48300	Wenatchee, WA	1.0070	1.0346	0.0276	2.74
48424	West Palm Beach-Boca Raton-Boynton, FL	1.0067	0.9649	−0.0418	−4.15
48540	Wheeling, WV-OH	0.7161	0.7010	−0.0151	−2.11
48620	Wichita, KS	0.9153	0.9063	−0.0090	−0.98
48660	Wichita Falls, TX	0.8285	0.8311	0.0026	0.31
48700	Williamsport, PA	0.8364	0.8139	−0.0225	−2.69
48864	Wilmington, DE-MD-NJ	1.0471	1.0684	0.0213	2.03
48900	Wilmington, NC	0.9582	0.9835	0.0253	2.64
49020	Winchester, VA-WV	1.0214	1.0091	−0.0123	−1.20
49180	Winston-Salem, NC	0.8944	0.9276	0.0332	3.71
49340	Worcester, MA	1.1028	1.0722	−0.0306	−2.77
49420	Yakima, WA	1.0155	0.9847	−0.0308	−3.03
49500	Yauco, PR	0.4408	0.3854	−0.0554	−12.57
49620	York-Hanover, PA	0.9347	0.9397	0.0050	0.53
49660	Youngstown-Warren-Boardman, OH-PA	0.8603	0.8802	0.0199	2.31
49700	Yuba City, CA	1.0921	1.0730	−0.0191	−1.75
49740	Yuma, AZ	0.9126	0.9109	−0.0017	−0.19

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